CHILD SURVIVAL X:

Action for Survival, Action for Progress in Micronutrient and Cbiid Nutritiin in the Philippines

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MIDTERM EVALUATION

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SUMMARY

The Midterm Evaluation of HKI Philippines' Child Survival X Project: "Action for Survival, Action for Progress in Micronutrient and Child Nutrition in the Philippines" took place from August 3-16, 1996. This project is being implemented in target municipalities of eight provinces in the Eastern Visayas and Bicol regions by Helen Keller International, with funds from USAID/BHIUPVC and HKI, in collaboration with the Department of Health @OH).

Evaluation team members and authors of this report are Ms. Margaret Ferris-Morris, MS, external consultant and Mary Ruth Homer, PhD, Nutrition Advisor for HKI Headquarters. Information-gathering methods included: visits to six participating provinces; interviews with the Provincial Task Forces (PTFs), national, regional, provincial and municipal DOH counterparts, mayors, mothers and *barangay* health workers (BHWs); review of training curricula, reports and materials; review of the DIP and Annual Report; field observations during Advocacy Forums and training sessions; and discussions with project staff.

Beginning in October 1994 and in the ensuing 22 months, HKI's CSX staff has: worked with national level counterparts to develop an integrated strategy for child development; selected provinces; undertaken the baseline survey; mounted sensitization and orientation training for eight newly-formed Provincial Task Forces; developed a ***Child Growth Basic Learning Package*** (comprising a reference guide, training modules, comics and counselling cards); translated the training activities and counselling cards into seven languages (now at printing stage); trained eight PTFs as trainers for midwives; coordinated 12 training courses for midwives in eight provinces and 10 BHW courses in five provinces; designed, implemented and evaluated four provincial-level Advocacy Forums for Mayors; and designed and implemented the first Salt Forum in the Philippines. Some project activities were delayed due to national elections.

Main project accomplishments to date are: forming and energizing eight PTFs as a focus for advocacy and action; learning how to attack malnutrition through democratic LGU processes, and making strategic use of materials produced, e.g., eight provincial ***Health and Nutrition Situation Reports;*** producing a comprehensive ***Child Growth*** package for training; and maintaining HKI's role as major NGO technical advisor to the National Nutrition Service.

This project is atypical for the Child Survival Program and represents fairly "unchartered waters" for U.S.-based PVOs such as Helen Keller International. Even though HKI has considerable experience as a technical assistance PVO, it has not applied these skills outside the health sector. The LGU system now mandates that NGOs interested in health [and any other issue] learn how to negotiate through the newly-organized bureaucracy at different levels of political authority. Devolution of the health system is pruving to be quite complex among governmental Departments, thus creating a particularly challenging environment. HKI's CSX project is meeting this challenge and making remarkable progress so far.

Total costs of the Midterm Evaluation, including the two members of the evaluation team and excluding local staff time, are approximately $2 1 ,000. The results of the evaluation were discussed with all project staff in country. Further feedback will include a response by the staff to the evaluation and follow-up by HKI New York.

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Non-English Terms

Atuw ng Sangkup Pinoy (ASAP)	Philippine campaign against micronutrient malnutrition
bamngay	village
purok	sub-division of a ***barangay***
lugaw	weaning food

ACRONYMS

AC	Area Coordinator
BHW	***barangay*** health worker
CARE	US private voluntary organization
CPCIV	Country Program for Children IV
CGP	Child Growth Basic Learning Package
c s x	U&AID/Child Survival (cycle ten)
DECS	Department of Education, Culture and Sports
DIP	Detailed Implementation Plan
DOH	Department of Health
FLANE	Fun Learning Activities for Nutrition Education
GOP	Government of the Philippines
HKI	Helen Keller International
LGU	local government unit
MATA	Mobilizing Action through Technical Assistance
MNAO	Municipal Nutrition Action Officer
MHO	Municipal Health Officer
MTE	mid-term evaluation
NGO	non-governmental organization
NMAT	National Micronutrient Action Team
NNC	National Nutrition Council
NNS	National Nutrition Service of the DOH
PIA	Philippines Information Agency
PEM	protein-energy malnutrition
PPDC	Provincial Planning and Development Coordinator
PHN	Provincial Health Nurse
PHO	Provincial Health Officer
PNAO	Provincial Nutrition Action Officer
PTF	Provincial Task Force
PVO	Private Voluntary Organization
RHM	Rural Health Midwife
TQM	Total Quality Management
UNICEF	United Nations Children's Fund
VAC	vitamin A capsule
VAD	vitamin A deficiency
VITAP	Vitamin A Technical Assistance Program
VITEX	Expansion of Vitamin A Supplementation and Nutrition Education Interventions

I. BACKGROUND

This document presents the results of the mid-term evaluation (MTE) of 'Project 'ASAP' Action for Survival, Action for Progress in Micronutrient and Child Nutrition' (October 1994 -September 1997). This project is being implemented by Helen Keller International (HKI), with funding from the USAID/PVC Child Survival X (CSX) program and HKI, in collaboration with the Department of Health and local government units (LGU) in eight provinces in Regions V and VIII, the Philippines. See map on the following page. (Note: For the purposes of this document, Project 'ASAP' shall be called CSX, so it will not be confused with the Department of Health's @OH) national micronutrient supplementation effort, ***Araw ng Sangkap Pirwy*** or ***ASAP.)***

This current project is an outgrowth of two earlier projects: Project MATA (Mobilizing Action through Technical Assistance) and Project VITEX (Expansion of Vitamin A Supplementation and Nutrition Education Interventions). Among other activities, Project MATA developed NGO (non-governmental organization) coalitions to advocate for micronutrient programs, particularly vitamin A, and Project VITEX developed ***Weaning*** Moments, a learning package composed of a training manual, book and complementary materials addressing weaning age malnutrition. For CSX, the ***Weaning*** Moments learning package was revised and expanded to include prenatal health and nutrition and child development for use by rural health midwives (RHMs) and volunteer ***barangay***[1] health workers (BHWs) with mothers.

The Project Director began her work on the CSX project in October 1994 and the Detailed Implementation Plan (DIP) was developed and submitted in March of 1995. The baseline survey planning process began in early 1995; the survey was implemented mid-1995; and preliminary analysis was completed by October. Pre-implementation activities such as orientations with counterparts at DOH and LGUs began in the first three months of 1995 and new field staff were hired in 1995. Organization of the eight Provincial Task Forces was completed a few months later than anticipated -- in July 1995, after the national elections took place. The training needs assessment and initial trainings took place in August and September 1995.

The project targets eight provinces in two regions which have the highest rates of child malnutrition and mortality in the Philippines: all six provinces in Region VIII (Samar, Northern Samar, Eastern Sarnar, Leyte, Southern Leyte and Biliran) and two provinces in Region V (Masbate and Albay). Eighty two of 177 municipalities are selected in these provinces, covering an approximate total population of two million. Most of the municipalities are located along the coast, while the rest are either lowland or upland municipalities. Two-thirds of the total population live in rural areas and one third live in urban areas. Farming and fishing are the two major industries. The CSX project is managed from HKI's main office in Manila, with two very small sub-offices in Legaspi, Albay and Tacloban, Leyte.

Preliminary results from the baseline survey found a prevalence of night blindness in children to be 0.4 %; anemia in women of child-bearing age to be between 59 - 74%; and the total

[1] ***Barangay*** in the Tagalog language means 'village'

CS X Project Location

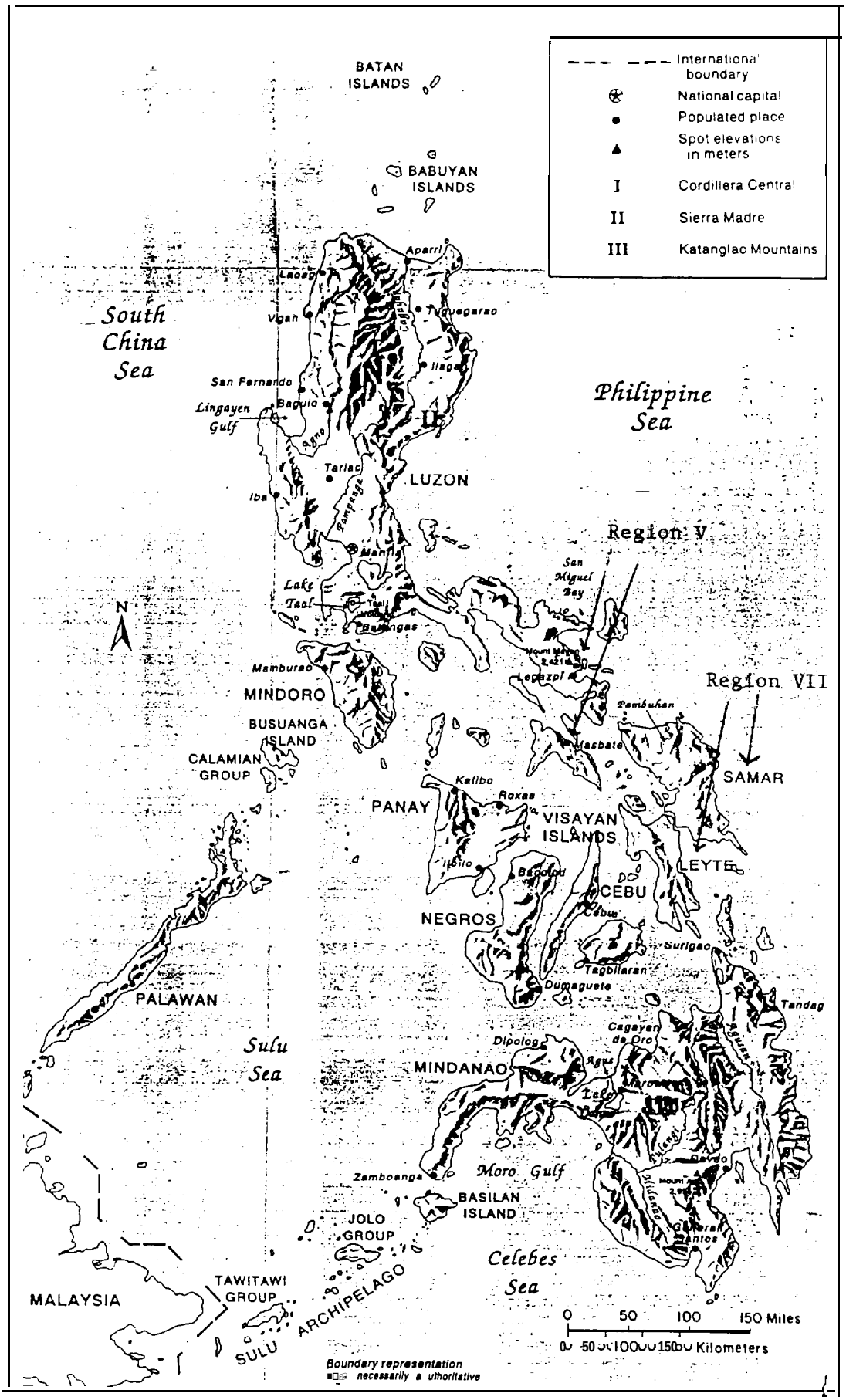

Figure 2. Topography and Drainage

goiter rate (TGR) range from 23-35% in the two regions. In terms of micronutrient supplementation, iodized oil capsule coverage ranged from 18-54% of the targeted women of child-bearing age and vitamin A capsule (VAC) coverage of more than one capsule annually ranged between 56% and 64% for preschool children. A small proportion of households reported using iodized salt (2% or less). The baseline survey addressed questions on household child feeding practices, vitamin A food consumption patterns, and knowledge and awareness about health, nutrition and micronutrients. Nutritional status was determined for children under two years of age.

The goals of the project are to assist the Government of the Philippines (GOP) to reduce morbidity, mortality and disability among women and children resulting from protein-energy malnutrition (PEM) and micronutrient malnutrition. HKI aims to strengthen community-based interventions to improve breast-feeding, complementary feeding, and consumption of micronutrient-rich foods or supplements.

II. METHODS

The mid-term evaluation took place in six of the eight provinces from August 3-16, 1996. The evaluation team comprised Ms. Margie Ferris-Morris, external evaluator, and Dr. Mary Ruth Homer, HKI New York representative. During the two weeks in country, the team undertook a variety of activities covering a number of aspects of the CSX project. The schedule for the two weeks, including persons interviewed, is presented in Appendix 1.

Information sources the team used for this evaluation are as follows:

1. **Field Visits** to six provinces where the CSX project is operational.

2. **Interviews** with Provincial Task Force (PTF) members, governors, mayors, municipal and provincial health officers, midwives, public health nurses, ***barangq*** health workers, mothers, salt market distributors, restaurant owners, an iodized salt producer, representatives of the Philippines Information Agency (PIA), Department of Health-Nutrition Service/Manila, National Nutrition Council/Manila and regional staff among others. Over one hundred persons were contacted and interviewed during the two-week MTE.

3. Observations of BHW training and mothers' classes led by midwives (RHMs); and **observations of advocacy forums** -- an advocacy forum for mayors in S. Leyte province and a salt forum of pertinent stakeholders for the promotion and distribution of iodized salt in Biliran province.

4. **Discussions** with HKI staff (New York and Philippines) involved with the CSX project.

5. Review of relevant documentation and USAID Mid-term Evaluation Guidelines for CS-X Projects.

III. ACCOMPLISHMENTS

A. Project Time and Objectives

HKI's Child Survival X project has been operating 21 months (from October 1, 1994 through August 1996, when this MTE took place), or approximately 60% of the three-year grant period. Some of the original project objectives as presented in the proposal were revised at the time of the DIP. Since the baseline survey was implemented after the DIP, some objectives were revised when the results became available and these revisions were reported in the First Annual Report. The revised objectives, planned inputs and planned outputs appear in Appendix 2.

B. Inputs and Outputs

The information provided in Appendix 2 focuses on the DIP's impact-level behavioral objectives and inputs and outputs related to training of health providers. The DIP does not include indicators for the several layers of intermediate steps which are required for eventually achieving desired behavior change and impact at the household level. This situation is discussed more fully in section VI A.

A summary of the project's actual inputs and outputs is presented in Table 1 in Appendix 3. Project activities are divided into three sections, i.e., pre-implementation, providing support to the Local Government Units and providing support to the National Nutrition Service. Since the majority of the activities implemented as of the MTE affect all three interventions (40%-Nutrition; 30%-Vitamin A; 30%-Iron and Iodine), these interventions are not identified explicitly in Table 1.

C. Outputs as Compared to Objectives and Expectations

If one compares the information in Table 1 to the expectations listed in Appendix 2 (from the DIP), it appears that the only item accomplished from among the original DIP objectives (Appendix 2) is the initiation of training for rural health midwives in using the Child Growth Basic Learning Package (CGP). In fact, the DIP mentions many of the actual process-type activities which were planned and have been undertaken; they just were not presented in the DIP (nor subsequently) as quantifiable inputs and outputs with indicators.

The project's particularly noteworthy accomplishments to date are:

1. **Eight Provincial Task Forces.** HKI has played a lead role in the formation, sensitization, training and support of eight Provincial Task Forces which are now undertaking a variety of advocacy and training activities. The MTE team met with six of these PTFs and observed three of them in action: the PTF of S. Leyte implemented an ***"Advocacy Forum on Nutrition"*** for all mayors in the province (August 6, 1996); the PTF of Biliran conducted a ***"Salt Forum ."*** for key stakeholders involved in promoting the availability and consumption of iodized salt (August 9, 1996); and the PTF of Masbate was midway through its first training of BHWs (August 13, 1996).

The PTFs are "known entities" in their provinces among provincial and municipal-level LGU officials and health providers. This recognition stems from their current level of activity and from their composition, as the majority of the PTF members also participate in their respective Provincial Nutrition Committees (PNC). For their part, the PNCs are the local body of the National Nutrition Council (NNC), which is officially connected to the Department of Agriculture.

PNCs vary considerably in their activity and clout with provincial officials. Similarly, and not surprisingly, the eight PTFs vary in their potential, most often due to the skills of their leaders and/or the very visible support given by the institutions represented on the PTF. The stronger PTFs have already demonstrated their potential as a multi-sector-al force for nutrition. An exciting example of this occurred during the presentation of ***the Health and Nutrition Situation Report*** to the Governor in Southern Leyte when the Governor offered 150,000 Pesos (US $4,200) for additional provincial nutrition program needs. The funds will be used in the near future for weighing scales and establishing additional weighing posts in ***barangqs.*** At the end of August 1996, this same Governor requested HKI's Area Coordinator (AC) to attend his budget meeting where he pledged an additional 60,000 pesos ($2,400) for nutrition activities and two million pesos ($80,000) for BHW honoraria @ 50P ($2)/month/BHW. More detailed discussion about the structure, functions and potential of the PTFs is in section VI A 2.

2. Attacking Malnutrition in a Democratic Society. The Local Government Code, signed into law in 1991, has had a profound effect on the delivery of health services in the Philippines. Devolution of resources from the national level to Local Government Units at the provincial and municipal levels has forced all NGOs who work in the health sector to become more "politically savvy" than ever in order to form effective partnerships to achieve their goals.

With support from this CSX project, HKI is meeting this challenge head on and forging new paths through LGU policies and processes. HKI is building a new body of knowledge for NGOs (and potentially those in the profit-making sector) by learning together with its PTF partners and teaching others how to work within the LGU system. For their part, the PTFs and health providers at all levels are learning to work with their new governmental supervisors: selecting key data for political decision-making, turning nutrition information into action, building expertise in advocacy and developing new and effective coalitions for nutrition improvement.

In short, health services which were planned, implemented and evaluated in a top-down manner from Manila have now devolved such that their locus of decision-making and resource allocation is controlled by politicians who are leaders of provinces (as governors), of municipalities (as mayors) and of ***barangays (as*** captains). On the positive side, HKI and its partners are interacting with decision-makers who are "closer to the action", i.e., closer to mothers in communities, and "lower in the chain" of power; on the negative side, HKI must deal with additional layers of bureaucracy, outside the health sector, and must do it in many more geographical locations than ever before because of the greater independence now afforded to the LGUs.

3. Documentation of Inputs - As reflected in Table 1, much of the time invested in this project to date has been in a wide variety of group settings. HKI has a keen understanding of the relationships among these events and has carefully documented inputs, including design and proceedings of advocacy and training sessions and steps involved in creating promotional materials.

4. **Child** Growth **Basic** Learning Package - In some cases, the major prcxluct from a three-year project is a training manual. For this CSX project, the key training product is not only ready for use well before the end of the grant period, it is actually a package of thoroughly tested and reviewed materials: a Reference Guide for trainers; a comprehensive manual of training activities; a series of comics; and Counselling Cards'. These materials are already in use in English and Tagalog and translations into five additional languages are almost completed. See more details in section VI C, Community Education.

5. Support to National Nutrition Service Initiatives - HKI's role as technical advisor to the National Nutrition Service (NNS) has grown in breadth and depth since HKI began working in the Philippines. This role is unique for an NGO and reflects the mutual respect shared between HKI and its main government counterpart. In the context of CSX, HKI provides technical assistance to the National Micronutrient Action Team (NMAT). HKI supported workshops for the NMAT to develop the National Micronutrient Operations Plan, which now is also being assisted by a centrally-funded USAID project, Opportunities for Micronutrient Interventions (OMNI).

On an on-going basis, HKI assists the NNS with policy and planning with regard to the country's two nationwide micronutrient distribution days: ASAP in October and National Immunization Day in April. Data from each event are reviewed and revisions made for the sequel. In 1995, HKI: designed and produced separate ASAP guidelines for health workers and local volunteers; participated on the national training team; produced promotional banners and proposals to obtain corporate support for materials and publications; participated as members of the national technical, social mobilization and communications committees; and catalyzed ASAP training and promotional activities in the 13 provinces where HKI has a field presence with CSX or other projects. As a result of these activities, HKI can truly be credited with assisting in improving the micronutrient status of vulnerable groups nationwide: for example, the Third Annual ASAP reached 8.6 million children with vitamin A capsules; and 11 .O million women with iodized oil capsules.

IV. EFFECTIVENESS

Given the nature of this project, there are no standard Child Survival implementation guidelines against which HKI's CSX staff can easily set targets and measure progress. The MTE team bases its conclusions and recommendations on the information reviewed and gathered during its visit. Initial rounds of training activities with midwives and **BHWs** began in May **1996** and are scheduled to continue until October. Therefore, targeted high-risk

[2] *Counselling* is the spelling form used in the Philippines

groups, i.e., mothers and their preschool children, are not yet being reached to any large degree by the project. However, the evaluators agree that the activities which have preceded the RHM and BHW training are absolutely essential to reaching the targeted high-risk groups, with appropriate messages in a learner-friendly environment and with a sustained level of two-way communication which can bring about the desired behavior changes.

The MTE provided an opportunity to assess progress to date compared to the stated objectives. In the absence of a more articulated work plan after the DIP and yearly targets, the MTE team was asked to recommend a series of process indicators to monitor project progress and processes. While the baseline and endline surveys will evaluate the project's overall objectives in effecting behavior change among mothers, the process indicators introduced will capture the activities and strengths of the PTFs and changes they are promoting among governmental, municipal and *barangay* officials which will facilitate and promote the desired changes with mothers. Initial discussion with the CSX staff indicated that considerable evidence is already available to evaluate many of the process indicators which they will use from now on.

Strengths: The strengths of this project, which have facilitated its considerable achievements to date, are:

- The CSX intervention is in an area in Eastern Visayas which is high in micronutrient deficiencies and highest in child mortality in the Philippines;
- The project's focus is unique in that the approach is to strengthen the local capabilities to implement nutrition interventions, serve as advocates to combat micronutrient deficiencies and promote village level behavior change. This focus promotes sustainability in the environment of devolution that currently characterizes the GOP;
- HKI specifically draws on experience and materials from pre-cursor projects, e.g., Projects MATA, VITEX, and VITAP (Vitamin A Technical Assistance Program);
- Local communities have been taken into account in the design of the project;
- HKI's relationship with the GOP is strong and their position well respected, likewise its relationship with USAID/Philippines;
- Project staff include very capable host country nationals which also enhances project sustainability; staff are known for their creativity and team work; and
- It draws upon its institutional memory (experiences) to prevent duplication of efforts and to continually improve upon design, outputs, products and ability to deliver technical assistance to others.

Constraints: The constraints under which this project is operating, which restrict it from making more dramatic progress in shorter time with fewer resources, are:

External Factors (largely outside of HKI's influence):

- The 1993 **Local Government Code** causes increased demand on local resources and in some cases shifts in priorities away from new activities and health and nutrition issues. Constraints include:
  - Budget Reduction. Only 5% of total provincial IRA (money from national budget) is allocated for health and can be augmented or decreased at discretion of local

authorities. Provincial travel budgets were reduced by half after devolution;
- Reluctance and resistance within certain sectors of the local government to proceed with new devolved plan;
- Chain of authority stops at the governor (for the province) and the mayor (for the municipality); therefore, the DOH can not mandate programs from Manila to the provinces (top down) except for selected cases (e.g., ASAP, National Immunization Day); and
- Local interest in and demand for nutrition and health services varies depending largely upon leadership and existence of local advocates. The CSX project is designed to influence this factor.

- Election process delayed start-up of some interventions by about six months
- Difficulty with getting dispersement of funds from UNICEF for four of the provinces has delayed some activities
- Devolution of over 40,000 central-level health staff to the provinces overburdened the health budget of some provinces and municipalities. Some provinces have over staffed health programs

Internal Factors:

Local Government Units
- Need for nutrition-related implementing agencies to identify local resources since the Local Code took effect: local budgets in these provinces appear to have shortfalls, due to the fact that salaries and operating hospitals expends most of the health budget. For example, in Masbate, most of the total provincial budget goes to one Department, leaving little for health and nutrition, forcing other Departments to find local and other resources to maintain operations;
- Need to coordinate and consolidate funding for health and nutrition within different government entities implementing nutrition programs, i.e., nutrition is everyone's concern but also no specific department has the authority to coordinate all nutrition activities;

Design
- Dietary change objectives listed in DIP are too ambitious to realistically accomplish within three years;
- Project focus is on two levels: strengthening National and LGU systems and staff capabilities while implementing a full-scale project at the community level with the objective to effect behavior change. Most projects attempt one ***or*** the other; hence staff are drawn in two directions;
- Lack of initial development of clear monitoring plan, including e.g., HIS (health information system), indicators, who is tasked to conduct monitoring, when, etc.;

Staff
- Limited field staff (2 Area Coordinators for a large area -- 8 provinces and 82 municipalities);
- High workload for PTF members in the field;
- Processing and analysis of the baseline survey still demands time and attention of staff and draws away from other activities;

Time
- A small field staff and initial focus on provincial-level capability building has delayed

municipal-level activities; and
. Little or no time to document the process, outputs and successes, particularly at the LGU level.

In short, the project **is** behind schedule if only evaluated in terms of its demonstrated progress towards creating behavior change within households. It is **not** behind schedule when evaluated in terms of the necessary steps which **must** be taken and which **are** being taken to work within the evolving LGU system in the Philippines and the time which must be invested in each step, in each province, municipality, community and eventually in each household.

V. RELEVANCE TO DEVELOPMENT

The Child Survival Project attempts to integrate the development efforts related to mothers of child-bearing age, and child survival of infants and young children with the ongoing efforts in the community as outlined in the Country Program for Children (CPC IV) which is part of the Philippine Plan of Action for Children (See Appendix 4). **The** objectives of these multi-year plans are to complement and strengthen the ongoing training efforts of the DOH. However, HKI is attempting to address a larger and necessary process -- dealing with the realities of devolution and trying to improve the processes to obtain the objectives they have outlined. UNICEF is supporting CPC IV activities in nine provinces through a Child Growth grant to HKI. Four of these provinces are the same as the CSX project. UNICEF's support includes the printing of the majority of the training materials developed to date for the Child Growth Basic Learning Package which is used in all 13 provinces where either the Child Growth project, the CSX project or both are operating.

HKI and the PTFs have incorporated some of the same language and indicators in their planning documents as used by the Government of the Philippines when addressing overall issues of human development. Specifically, the objectives outlined in the Provincial Nutrition Plans developed by the PTFs include the same indicators used to determine which provinces are part of the Social Reform Agenda, as well as indicators used to measure Minimum Basic Needs, e.g., to assess PEM, reductions in micronutrient diseases, vitamin A capsule coverage and household use of iodized salt.

VI. DESIGN AND IMPLEMENTATION

A. Design

1. *Project Objectives*

Scope: The objectives in the DIP (Appendix 2) focus solely on behavior changes at the household level, neglecting the process objectives for **LGUs** and at the national level. Process-level objectives should be delineated and added to the DIP, and ambitious behavior objectives modified and reduced in scope for each province (See section VIII CONCLUSIONS AND RECOMMENDATIONS, Recommendations I A, l-4).

Reaching end-of-project goals: The rationale for this change stems, in part, from the delay of the intervention phase of project due to the May 1995 elections; the necessity to translate and print materials before the training (some materials are translated into seven languages); and the need to have the PTFs trained before the **RHMs** and **BHWs** are trained. In other words, an extensive series of trainings needed to take place before mother's classes and counselling could commence. Hence, the training phase of **BHWs** on the use of counselling cards is just beginning (August 1996). To achieve the impact objectives stated in the DIP, household level behavior change would have to take place in just one year, which is probably insufficient time for some changes to take place even under the best of circumstances Therefore, HKI needs to consider an extended timeframe for reaching its CSX goals (Recommendation I B).

2. Project Interventions

The choice of the project interventions relates directly to the need to work through the recently devolved government system to promote nutrition programs and to the need to address some of the principal causes of morbidity and mortality of young children in the two regions. Based on the preliminary results from the baseline survey, the project interventions are addressing important health and nutrition problems facing mothers and children.

The design of the CSX project is two-pronged: interventions at the National and LGU level to provide technical assistance and training; and interventions at the ***barangay*** household level designed to change mothers' food and health-related behavior. The approach HKI is taking is different from the typical child survival intervention, which focuses intensely at the village level. However, the challenge in addressing the two prongs in depth remains. To date, the project's interventions at the LGU have focused primarily at the provincial level. To support the health and nutrition activities at ***the barangay*** level, municipal LGU capacities must also be developed.

Restructuring of the Provincial Task Forces: The PTF is by and large structured in the same pattern as the Provincial Nutrition Council (PNC). The member representation is nearly the same, with the exceptions that the PTFs include Provincial Planning and Development Coordinators (PPDC) and representatives of the Philippines Information Agency and Department of the Interior and Local Government. The functions are slightly different, especially due to **HKI's** role in establishing **PTFs** for this CSX project. Hence, the Task Force may not hold a distinct enough view of itself to be 'freed up' to do other activities. Subcommittees can be created to work more in depth on training, advocacy, information dissemination and nutrition planning and monitoring. The talents of the non-health PTF members could be capitalized on, for instance:

- The **PIA** member could come to a RHM or BHW training to **REPORT** on it, make a story, go to the village and get a story from a mother about what she thinks of the new style of training and counselling; basically play the role of information dissemination;
- The PPDC can hold informational meetings with his/her Board and can explore other avenues of funding; and

- Other members could collect data on one or two key issues, monitor and perform other tasks specifically related to their regular job.

Consider developing subcommittees for the PTF which deal with specific issues that:

1. Have been identified by the whole PTF as important - remain focused with not too many issues;
2. Can be accomplished within a relatively short time frame (6-12 months) and are ones where they can have EARLY successes, to encourage them to go on;
3. Have a common interest to the subcommittee members, i.e., they are excited about working on that problem, and
4. Overlap with particular expertise of the subcommittee members.

Consider conducting a stakeholder analysis of the provincial nutrition problem and determine if other members need to be a part of the PTF. PTFs can be somewhat fluid, calling in members who may not attend all the meetings but who can add information and participate in the process at key times. For instance, additional persons from the Provincial Planning and Development Office may want to be a part of finding the solutions for key nutrition problems in the province. Their involvement in the process may motivate them to be more creative and more committed to the problem. Having non-traditional health people involved stimulates more creative solutions to a multi-faceted problem, instead of keeping nutrition issues within the realm of the DOH. A schematic showing the two proposed PTF subcommittees and their members appears in Appendix 5.

Task Force Identity. The question is, how do the PTFs see themselves? They need a mission statement, name and clear identity. Presently, it is not clear whether or not they are a part of the PNC, or if it is advantageous to be associated with the PNC at all. In two provinces, the PTF members thought that this issue should be discussed among the group for a decision and the MTE team agrees. A clear identity for the PTF is KEY to a successful PTF. The PTF needs to have a 'bigger picture' view, a sense that they can accomplish more over the years (Recommendation II A).

The MTE team observed two of the PTFs implementing advocacy events, i.e., the PTF of S. Leyte sponsored an Advocacy Forum for Mayors and the PTF in Biliran sponsored a Salt Forum. The MTE provided suggestions to HIU Philippines for increasing the participatory nature of these events and for making them more specifically directed to the stakeholders in the audience (Recommendation II B).

In conclusion, all PTFs will need continued, yet varied, support from HKI to grow professionally, gain more widespread attention for their efforts and to achieve the objectives of the CSX project.

Municipal Task Forces: To achieve the recommended revision of objectives, intervention efforts need to be directed at the municipal level in addition to the provincial and national levels. Replication of the Provincial Task Force in a few select promising municipalities would be an obvious approach, as reflected in the schematic in Appendix 5. Re-activating municipal nutrition committees would be another approach. Various avenues exist to carry

this out, such as through quarterly meetings of provincial departments (Agriculture, Health, Social Welfare, Education, etc.) held with their counterparts in the municipalities, or through monthly supervisory visits where a provincial department head or officer could identify candidate municipalities and active counterparts to reignite a nutrition committee or be part of a municipal nutrition task force.

These supervisory visits could also be opportunities to exchange ideas on advocacy and provide a feedback mechanism for activity monitoring of the CSX project. The League of Mayors also meets quarterly, another avenue for advocacy and identification of mayors/municipalities concerned about health and nutrition (Recommendation II C).

While it would be extremely difficult to address 82 municipalities presently covered by the CSX project, HKI could select a handful of promising municipalities to work in and using the PTF model, create municipal nutrition-action task forces or re-stimulate nutrition committees. These in turn would support and supervise the ***barangq-level*** interventions as well as advocate for nutrition programs and funds (Recommendations I A, 1+2 and II C).

3. Training

Training by the PTF members: The initial training design called for training Provincial Task Force teams which would in turn train rural health midwives and ***barangq*** health workers. The adult learning and participatory methods were new and welcome techniques for most PTF members and their trainees. While the quality of PTF training of **RHMs** is high, it is time-consuming, lasting five days in a province. Training **RHMs** falls under the purview of some PTF members, but for others this is a new task, outside their field and on top of their normal duties. The PTF is also expected to train **BHWs** in use of the Counselling Cards from the Child Growth Basic Learning Package. For most provinces, this includes one to three trainings of **BHWs** lasting five days apiece. Time invested by the PTF in the initial trainings received (for needs assessment, planning, design of provincial nutrition plan, etc.) plus the training **PTF** members are expected to **give,** yields approximately 30 - 40 working days consumed in either receiving or giving training.

It is recognized that rather than conflicting with the other duties of municipal and provincial staff, externally-funded projects such as CSX often give opportunities for staff to perform more efficiently since technical assistance, supervision and financial support are frequently provided. For health- and nutrition-related staff involved in this project, the trainings are viewed as part of their normal duties. However, non-health staff expressed a common sentiment to the evaluation team that the workload is too high.

Recommendation: Since training of ***barangay*** health workers is just beginning, the **HKI** staff should **find** alternative trainers, preferably drawing from the municipal level health staff to complement the PTF health trainers. The non-health PTF members should be freed up to perform advocacy work, and develop and implement a provincial communications plan. This latter plan would be similar to the one which has already been prepared with mothers as the target audience. This new plan would include LGU members, Board members and other decision makers as the target audience. One of the materials included in this plan would be the provincial ***Health and Nutrition Situation Report*** (described in VI B 3), with its

distribution strategy. The non-health PTF members could also focus on identifying municipalities with potential for success and develop similar task forces who focus on municipal-level nutrition issues (Recommendation III A).

Training of RHMs: Based on observations of and interviews with **RHMs,** it seems that they view their involvement with **the** Child Growth Basic Learning Package as a short-term event, to be manifested in the ***burangays*** as a "class" offered to mothers. Mothers enroll, the 10 modules are covered, the mothers graduate, the class is finished and the RHM will go repeat the class in the next ***barangay***. The **BHWs** are then expected to take over with home visits using the Counselling Cards. This approach needs re-thinking, because more community volunteers are needed to spread the basic health messages to more mothers, more often and with more efficiency and effectiveness in order to reach the project's goals. Ideally, the RHM needs to develop a **mindset** where:

- her interactions with the mothers, vis-a-vis the Child Growth messages, become an on-going, daily way of life with mothers of preschool children, not just in the context of an informal classroom setting during a 1-2-week period where the 10 modules are presented, but year round, for as long as an individual mother has preschool children;
- she can call on other people -- **PHOs** (Provincial Health Officers), **PHNs** (Public Health Nurses), **MHOs** (Municipal Health Officers), **BHWs,** PTF members, ***barangay*** volunteers and officials -- to help her reinforce the Child Growth messages, to assure the messages are consistent and to otherwise support her efforts; and
- she serves as a 'team leader' of the **BHWs,** providing supervision, in-service training and support.

Given the current structure of the DOH in the Philippines, it is not likely that the CSX project can help facilitate widespread training of **RHMs** as 'team leaders'. Nevertheless, if several **RHMs** can be identified who already are functioning as described above, or have the potential to, the PTP can be encouraged to provide specific support for them in order to facilitate and accelerate mothers' capacity to adopt the CSX project's intended behavior changes (Recommendation III B).

Training of PHNs. **MHOs** normally supervise public health nurses, who supervise midwives, who in turn supervise ***barangay*** health workers. **HKI's** original training design included **PHNs** in the initial adult learning, facilitation, and participatory techniques training. However, financial cuts and other circumstances prevented this from happening in five of the eight project provinces. Nurses who haven't participated in the training are unable to adequately supervise the midwives for this project. The HKI staff recognize this is important and will attempt to orient the nurses on the CGP in addition to providing supervisory and monitoring skills training in the near future. (See also related comments in section G, Supervision and Monitoring).

Recommendation: Design a brief orientation workshop for municipal-level **PHNs** in the HKI-focused ***barangays*** covering: orientation to the Child Growth materials (Basic Learning Package), adult learning, counselling, facilitation and participatory learning skills, supervisory styles, and development of a monitoring plan (Recommendation III C).

4. Monitoring

One important component not given early attention in the project was the development of a monitoring plan for both the processes at the LGU level and their subsequent impact. Although the MTE team was asked to provide guidance for a monitoring plan and indicators for the LGU processes, earlier attention to this would have allowed the project to establish this aspect of the overall baseline and track progress at the beginning of the formation of the Provincial Task Forces. An additional difficulty was the plan for the PTFs to monitor the implementation of the project at *the barangq* level. Given the present PTF responsibilities with the project, it would be taxing for the PTFs to conduct all levels of monitoring the municipal and *barangay* activities. One component which has been monitored in a very timely and sufficient manner is trainings and production of materials for the project.

Recommendation: As requested, the MTE team drafted a list of potential process indicators for this project (Appendix 6) and discussed with the HKI staff how a monitoring plan can be built around them (Recommendation IV A). Due to the nature of this project, these indicators stress quantitative and qualitative characteristics of outputs and impact (Recommendation IV B). The monitoring system should: allow for some spot check monitoring by the Provincial Task Force; prompt public health nurses (one per *barangay)* to monitor and provide feedback to the RHMs; and appoint a *barangay* Captain, *barangay* Nutrition Scholar or especially astute BHW to monitor the BHWs. The PTF can monitor training quality, classroom arrangement, use of materials in local language, and number of classes the RHM has conducted (via unannounced spot checks). PHNs can monitor content, style, number of mothers present, RHM schedules, use of materials in the local language, and classroom arrangement. The RHM and/or the BHW (supervisor) can monitor the BHW counselling of mothers, number of sessions, results, occasional visit to mother to see how counselling went, etc. (Recommendation IV C).

B. Management and Use of Data

1. Formative Research

At the beginning of the CSX project, a knowledge, attitudes, practices (RAP) survey was developed and conducted in four provinces (Child Growth provinces) with the Provincial Task Forces. The information was analyzed by the PTF and used to develop new modules which were not in the *Weaning* Moments Learning package (from Project VITEX). This expanded and improved set of materials then became the Child Growth Basic Learning Package: Child Growth Reference Book for midwives, Child Growth Training Activities for use with mothers' classes, Child Growth Counselling Cards for *use* by *barangay* volunteers and comics for mothers. While the PTF found collecting data somewhat tiresome, they appreciated learning survey techniques, such as focus group discussions and the proper conduct of a community-based survey. The product of this survey and HKI's earlier experience in developing *Weaning* Moments was the basis for all subsequent trainings for midwives and *barangq* health workers.

2. Baseline Survey

Extensive baseline data for indicators of micronutrient deficiencies and mothers' health behaviors were collected in the eight provinces. These data include: iodized salt use, iodized oil capsule coverage and Total Goiter Rate; coverage of iron supplements and prevalence of anemia in women; VAD ([vitamin A deficiency] as prevalence of nightblindness), VAC coverage through national supplementation days and other service delivery points, mean food scores (HKI Food Frequency Method) and food consumption patterns of children; nutritional status of children; breast-feeding and infant/child feeding practices; mothers' sources for health and nutrition information; and mothers' knowledge of key facts on vitamin A.

The above data was collected at the provincial and household level by a consultant firm hired by HKI. The use of a consultant firm meant some loss of control and quality, and created confusion in interpreting some results. For the endline survey, HKI is planning to conduct the survey with in-house staff (see Section VI I). At the time of the MTE, HKI was still involved in processing, coding and analyzing baseline survey data.

The results of the baseline survey were shared with the PTF during a training, and served as an eye-opener for the nutrition situation in their provinces. For most PTF members, this was the first time they had local data and saw the proportions of their population which were affected by diseases and nutrition-related problems. In some cases, the information differed from data they were compiling for the ***Health and Nutrition Situation Reports (see*** section which follows) taken from secondary sources. HKI used this opportunity to explain differences in sensitivity of data due to data collection methods. To assist the PTFs with subsequent private presentations to their governors and mayors, HKI provided each PTF with its respective baseline survey data on transparencies.

Governors and mayors in turn viewed local ***data - some for the first time*** - which was collated and presented in an easily understood format. Among these government officials, many were not aware of the nutrition situation in their own or surrounding constituencies. It is anticipated that the Provincial ***Health and Nutrition Situation Reports*** compiled by the PTF will become a basis for decision-making. For example, Dr. Pastor, the Provincial Health Officer in Biliran, told the Task Force, "We don't have a nutrition problem in our province". After seeing ***the Health and Nutrition Situation Report*** compiled by the Task Force using data from Biliran, he recognized that there was a problem.

The advocacy forums sponsored by the CSX project, held for all mayors in a given province, also serve as a means of exposing the governor and mayors to current information about health and nutrition in their respective municipalities and provinces. At the forum the MTE team attended, mayors took note of where their municipality stood in terms of rate of malnutrition and other health indicators in relation to other municipalities.

3. Health and Nutrition Situation Report

A large effort (by the PTF with technical assistance from HKI) was directed at collecting data from a variety of sources to create a major advocacy tool for each province called the ***Health and Nutrition Situation Report 1995***. The Reports, approximately 30 pages long, with

attractive glossy covers, also include a "Message from the Governor" (see Appendix 7 for representative sections). Data include similar topics as those covered in the baseline survey, and other key child survival indicators such as access to and use of oral rehydration therapy, immunization coverage, access to safe drinking water, types of sanitation facilities and number of households with environmental sanitation services, leading causes of mortality, nutrition and health services and programs in the province. The report also emphasizes the need to invest in micronutrient programs in terms of labor savings, educational performance and safe motherhood and child survival.

Some examples of how ***the Health and Nutrition Situation Report*** has been used to make decisions:

Members of Department of Education, Culture and Sports **(DECS)** went back to collect more data. Municipalities were ranked by priorities; travel schedules were synchronized to reduce transport costs; additional resources identified; and the respective agencies' plans were integrated into a provincial plan. At least one Governor (S. Leyte) pledged more funds for nutrition right on the spot (mentioned earlier in Accomplishments). And, after attending the advocacy forum in S. Leyte, the mayor of **Sogod** requested the PHN to organize training for ***the Barangay*** Nutrition Scholars (community-level nutrition volunteers) and allocated funds for this purpose.

4. Training Needs Assessment

A training needs assessment was conducted with **PTFs** to assess their training and resource needs at the municipal level. Information was then integrated into the training design for future trainings with the PTP.

5. *Workshop Documenmtion and Pre/Post Workshop Evaluations*

Each workshop conducted by the CSX project to date has been thoroughly documented in terms of development of design, rationale, activities and outputs. Routine pre- and post-workshop testing has helped modify the training and gauge performance at the end. This documentation process, which HKI has carried out in other projects, becomes a 'training databank* which HKI staff can draw upon for future trainings when certain tools, exercises and particular trainings are needed. A summary of all training events implemented to date is in Appendix 8 and the list of training designs developed is in Appendix 9.

6. Qualitative Documentation of the Project

Monthly reports are submit&l by the two Area Coordinators, which are then summarized into a brief monthly report sent to HKI New York. Although anecdotes and issues are reported, as well as progress made, HKI is not capturing some of the positive evidence which is crucial for:

- building a case with the quantitative and qualitative facts about what this project has accomplished;
- creating an 'ammunition belt' of true stories which can be used in advocacy

situations, often more effectively than quantitative data due to the background of the listener;
- developing a database of qualitative results to be used for the next proposal, the final evaluation and HKI's own 'institutional memory'; and
- sharing the team's accomplishments among the HKI staff.

Recommendation: Reporting of successes, examples of accomplishments and progress indicators needs to be done more routinely, assisted by the proposed indicators in Appendix 6 and suggestions in Recommendation IV B. Examples of tools for documenting these accomplishments were given to HKI's CSX Project Manager.

C. Community Education and Social Promotion

At the national level, the CSX project has developed the following promotional materials:

- ***Araw ng Sangkap Pinoy*** Volunteer's Guide 1995 - a guide for volunteers who participate in implementing ASAP activities
- ***Araw ng Sangkap Pinoy*** Flyer - to promote and encourage mothers to participate in the ASAP activities

and assisted in the development of a National Micronutrient Plan. Also, HKI staff provide technical assistance and feedback on DOH-generated materials.

CSX project efforts at the LGU level can be clearly divided between:

1) health promotion and social mobilization - These efforts are directed first at the key health professionals (PHOs, their provincial-level staff members and MHOs) and then at their provincial and municipal LGU "employers", respectively; and include the following materials:

- ***Health and Nutrition Situation Reports 1995*** - for eight different provinces, used with health professionals and LGU officials for planning and prioritizing provincial resources; and for educational, promotional and advocacy efforts among governors, mayors, and their staffs
- ASAP 1996 Bulletin for mayors and LGUs
- ***"Ano Ang Nutrisyon: A Resource Manual on Nutrition Problems and Programs"*** (Advocacy Kit; in draft, Aug. 96)
- Overheads with data from the Baseline Survey used in meetings with governors and other LGU officials
- Examples of draft letters to the governor and presentation suggestions for LGU officials
- Videos on ***"Ending Hidden Hunger"*** and ***"Battle Against Nutritional Blindness", used*** in training RHMs and BHWs, and scheduled for use with Municipal Health Officers

2) service provision - This relates to the training of MOH staff (RHMs) in the use of the Child Growth Basic Learning Package and the community-level BHWs in the use of the Counselling Cards. The CGP comprises:

- A Reference Guide - for use by trainers and **RHMs**
- Training Activities - a lO-module manual with comprehensive training plans for each topic; expanded from HKI's ***Weaning Moments*** manual
- Comics - a series of five; the latest one was developed for the Child Growth project; for distribution in mothers' classes, during counselling and at EPI (Expanded Programme on Immunization) visits
- Counselling Cards - a set of large, laminated cardboard cards, approximately one-half the **size** of typical flipcharts; expanded from HKI's ***Weaning Moments*** cards; with pictures on the front for mothers and text on the back to guide **BHWs;** bound together with a plastic spiral

To date, efforts in these two areas have been fairly evenly balanced. Training events to develop and use promotional and advocacy tools have been on-going since the beginning of the project and are described in detail in section D below; a list of workshops is found in Appendix 8. Parallel activities in service provision have focused on designing, implementing and applying the RAP assessment for completing the Child Growth Basic Learning Package (the **KAP** assessment is described above in section B). By the time of this MTE, training had begun with **RHMs** and **BHWs**.

The magnitude of this CSX project becomes quite apparent when considering the translation effort required for the CG Training Activities and Counselling Cards. Even though the **RHMs** and to a certain extent, even some of the **BHWs,** are comfortable reading English, they are much more comfortable with materials printed in their local language. Therefore, the Training Activities manual, Reference Guide and the Counselling Cards are being translated into seven languages: Tagalog, Cebuano, Woray, Bikolano, **Masbeteño,** Ilonggo and Ilocano.

The first draft into a local language was done by members of the Provincial Task Forces, then reviewed by HKI and input. The input version was then returned to the PTFs for their review and corrections and then again reviewed by HKI before final printing. All translations have been completed and these materials are now undergoing final layout, proofreading and printing. The English versions which have been used in training to date will be supplemented by local language versions as each becomes available.

Each of the 10 modules includes action-oriented participatory education activities for the mothers' classes, e.g., role plays, songs and games. Based on feedback from the **RHMs** who have finished their training and who are now using the Training Activities, the mothers enjoy the new participatory approach. The MTE Team noted that the **RHMs** need monitoring and feedback from more experienced trainers to ensure that they implement these activities correctly (See also section G on Supervision and Monitoring). The PTFs used pre- and post-tests in training the **RHMs** and the **RHMs** in turn plan to use this assessment method with participants in the mothers' classes. HKI needs to help develop monitoring tools and methods which the **RHMs** can use after training the **BHWs** to use the Counselling Cards and ones which the **BHWs** can apply after using the Counselling Cards with mothers.

To ensure consistency of the messages (both printed and in pictures), HKI always sends its draft materials to the Department of Health for review. For its part, the DOH does the same and asks I-IKI to review any new materials it develops.

Radio plugs are another medium which the CSX project is employing for promotional purposes. The radio plugs are modified from those developed by the VlTEX project with a new plug concerning pre-natal care and nutrition. Data for the **new** plug came from the qualitative survey; the PTF developed the drafts which were reviewed by experts in the DOH and National Nutrition Council; then they were pretested. The **PIA** will negotiate with local radio stations to air the plugs free of charge. The schedule for the remainder of 1996 is: pre-natal (September); breastfeeding and ASAP **[National** Micronutrient Day] (October); complementary weaning foods (November); and growth monitoring and promotion (December) and more radio plugs are planned for 1997.

D. Human Resources for Child Survival

Project personnel based in Manila are listed in Appendix 10. Staffing levels are adequate to meet the technical and managerial needs of the project, but the operational workload of the field-based Area Coordinators is very heavy with eight provinces and 82 municipalities to cover.

Recommendation: Funds permitting, a field-based staff assistant or an additional Area Coordinator would be ideal. And/or to facilitate their workload, cell phones would help maximize their efficiency during travel time. One AC needs a computer and printer and the other one needs her computer and printer upgraded (Recommendation V).

'Volunteers' for this project are many! Trained ***barangay*** health workers range from 80-150 per province. **BHWs** have a variety of activities aside from ***Child Growth*** counselling for mothers, including collecting sputum samples, calling mothers for Operation Timbang (annual child weighing) and immunizations, ***ASAP*** Day and National Knock-out Polio Day, and other duties as requested by the ***Barangay*** Captain and/or mayor. Their workload is not enormous, however these women have many other family and community duties. Although the dropout rate of **BHWs** is not being measured in this project, experience from previous projects indicated a 5% attrition rate. This was primarily due to job promotion, moving or increased family time needs. Presently, some mayors are giving **BHWs** a nominal stipend of between SO-300 **pesos/month**[3], an incentive which may have an impact on the drop-out rate.

E. Supplies and Materials for Local Staff

A number of printed materials have been developed by the CSX project staff for use at all levels - national, LGU (provincial and municipal) and ***barangay. These*** materials, designed for advocacy, training and counselling, are described in section C. Community Education and Social Promotion. In addition, report forms and iodized salt testing kits have been distributed for schools.

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[3] **25** Pesos = US$l.OO

All of these materials and supplies have been warmly received by HKI's operational counterparts as they respond to felt needs with appropriate items, well-designed for the intended audience. The PTFs need additional materials to continue to keep the attention of their LGU officials. During the MTE, a major regional newspaper, the ***Leyte-Samar Weekly Express,*** ran a front-page article called Malnutrition high in Samar" (Appendix 11). Although not placed by the PTF, the MTE team used this article as a means of drawing attention to the PTF during discussions with local health and LGU officials. The PTFs need to be active in using the newspaper and other media to raise awareness about their issues among the public and decision-makers. And, as HKI begins to work with the PTFs to develop municipal-level task forces, additional materials will be necessary for municipal audiences.

Recommendation: Develop additional advocacy materials for use by PTFs for nutrition and health promotion to the LGUs, such as follow-up one-page flyers focusing on one nutrition issue, model letters, press releases, and an advocacy presentation kit on a variety of nutrition and health issues that can be adapted for many different kinds of presentations (one is currently being developed and will be completed August 1996). Some examples were given to HKI/Philippines for consideration (Recommendation VI A).

All workers have had sufficient supplies of materials, however, the ***Health and Nutrition Situation*** Reports have only recently been available in the provinces. The exception is Northern Samar, formerly an HKI/VITEX project province, who has the ***Weaning Moments*** package (developed during VITEX). Training for the Child Growth Basic Learning package was not conducted during the CSX project for midwives and BHWs. N. Samar is the only province where CSX interventions have significantly differed from the other seven provinces. HKI staff will need to keep this in mind for the endline survey.

The DIP included plans to create a national nutrition newsletter for LGUs in coordination with the NMAT and NS. Given the investment of resources necessary for this type of output, and alternative information-sharing mechanisms already in place, the MTE team recommends that HKI delete this item from its plans (Recommendation VI B).

F. Quality

The project identified and documented the levels of specific knowledge and skills for the PTF members, midwives, BHWs and mothers. For the most part, this has been well documented in projects prior to CSX, where HKI worked with health workers and mothers during Projects MATA and VITEX and in the development of ***the Weaning Moments Learning Package.*** In fact, a real strength of HKI/Philippines is the approach taken towards identifying information needs of health workers and the subsequent development of appropriate health messages for mothers and child caretakers.

For the development of the Child Growth package, HKI first conducted formative research, including the testing of health messages with BHWs and mothers. The program messages improved from the ***Weaning*** Moments, upon which the CGP was based In addition, HKI recognized adult learning techniques as important and incorporated them into the training of

the PTF members as well as training for midwives and BHWs who conduct mothers classes and counselling. To account for the needs of this diverse group, PTF members were administered a training needs assessment before their training was designed.

HKI administered pre- and post- tests for all trainings, except for mother's classes. Mother's classes commenced the week of the MTE, hence no community-level project evaluation has taken place, outside the brief on-site visits and discussions undertaken by the MTE team, PTF members and HKI/Manila staff who accompanied them. The mid-term evaluators were unable to evaluate the essential knowledge and skills of mothers, health workers and PTF members during this visit. The participatory method of learning was well accepted and enjoyed by mothers, and midwives found it easier and more fun to teach since they did not need to stand up and lecture for the whole session. The MTE team's observations about follow-up and supervision for RHMs are described in section G.

G. Supervision and Monitoring

One of the strengths of this project is the familiarity of sites and counterparts shared among the field staff (the two Area Coordinators) and all of the program and management staff in Manila. The Manila-based program staff involved with CSX know the members of the Provincial Task Forces, Regional and Provincial DOH staff and other key contacts and vice *versa.* HKI places a high priority on field work, thus the Manila-based program staff spend 50-75% of their time visiting the eight project provinces and participating directly in project-related activities. Their roles are clearly understood and implemented as critical and active staff members of the project, not occasional passive visitors from Manila headquarters to the field. To date, one or more Manila-based staff members have served on the training team for every major CSX training event implemented in Manila or the provinces.

In general, one of the three Manila-based CSX program staff (the Deputy Director, Director of Communications and Director of Training [who is also the Project Manager]) is usually in the field and together, they spend from 10 to 15 days per month with each Area Coordinator. Due to the frequency of their direct interaction with the Manila-based staff in the field and subsequent communications by phone, the ACs' written reports usually serve to document information which has already been shared by other means.

Contacts between HKI's Area Coordinators and the six-to-eight member Provincial Task Forces occur approximately once per month for meetings and up to a full week for trainings. The role of AC is one of professional peer with the PTF members. The PTF has its own designated leader and HKI's AC brings a series of planning, organizing, administrative, counselling, management and training skills to their activities. While the AC does not have the authority to supervise the PTF, she does monitor their activities and provides overall guidance and support.

In all eight provinces, the PTF serves as the training team in introducing the Child Growth Basic Learning Package to RHMs. The RHMs officially report to municipal PHNs, so the PTF's role in providing follow-up to the training is not an authoritative one. Until the MTE, the responsibility of following up the training was not clearly articulated between the PHNs and the PTFs and neither group had any specific plans for this activity.

To date, the PTFs have not provided any systematic feedback to the RHMs they have trained. Given that this is more appropriately the PI-IN's role, HKI will consider adding orientation and training sessions for PHNs to the training schedule for RHMs. While the PTFs have a direct role in training the RHMs, supervision of follow up should remain with the PHNs. The PTFs should play a supportive role in follow up, for example: coordinating with the PHN and offering transportation to her when a member of the PTF will be visiting a specific *barangay*; assisting the RHMs with the graduation ceremony for mothers' classes, e.g., by helping to print certificates and getting them signed by the mayor and attending the ceremony; and providing technical assistance where needed.

HKI must address the expressed reluctance of RHMs to be trained with their supervisors. Given that the training of RHMs will be followed by training of BHWs, the need for monitoring and supervision (of RHMs and BHWs) will accelerate dramatically in the next few months. No supervision tools have been developed yet. Members of the PTFs have expressed their interest to HKI in being trained in monitoring and supervision in order to provide useful support to the RHMs and PHNs.

Recommendation: HIU needs to modify its training plans and designs in order to include PHNs as trainees (to become familiar with the Child Growth messages and the RHMs' role in delivering them) (discussed in section VI A 3 and Recommendation III C), and as sunervisors of the RHMs (this Recommendation). The PHNs should provide follow up supervision to the RHMs, who could *also* call on their MHOs, *barangay* captains and mayors to accompany them (and to provide the transportation). Have PHNs conduct some aspects of *barangay-level* monitoring such as quantity and quality of the midwives' mothers' classes, mothers' comprehension of the Child Growth messages, or occasional quantity and quality of the BHW counselling to mothers. PHNs can report problems to the PTF as necessary.

By the same token, once the BHWs have been trained in using the Counselling Cards, the PTFs should also assist the RHMs in their follow up, as necessary and as appropriate (Recommendation VII A). Follow-up seminars and refresher training are recommended components for the overall monitoring and supervision plan (Recommendation VII B).

H. Regional and Headquarters Support

The major support provided by HKI's New York office to this project has been for the baseline survey (see section I below). HKI New York provided matching funds for Chato Tuason, HKI Philippines' Research Director, to attend a short course on biostatistics and epidemiology (University of Michigan, USA) in order to improve her skills in these areas and decrease the need for future technical assistance. HKI New York's choice of Ms. Margaret Ferris-Morris to be the outside consultant for the MTE was due to her skills in team building for nutrition programs, advocacy, working with local decision makers to promote nutrition issues and overall expertise in international public health nutrition. The MTE is viewed as an opportunity to bring additional expertise to the project.

Communication channels and systems with HKI New York function well with the one exception of regular feedback from New York about the overall financial status of the project. HKI New York's Nutrition Division, comprising two full-time and one part-time

nutritionists, provide support to seven HKI Country Offices, some of which manage several nutrition projects. To date, **HKI's** Regional Director for Asia has not been able to provide any direct support to this project.

I. Use **of Technical Support**

1. External technical assistance received to dare - To date, CSX has received technical assistance from the following:

Baseline Survey:

a. Susan Burger, Ph.D., Nutrition Director, HKI-New York, visited twice to help design the baseline survey, analyze baseline survey data and prepare the DIP.
b. Jonathan Gorstein, Ph.D., Nutritional Epidemiologist Consultant, provided technical support to design the sampling protocol.
c. Ophelia M. Mendoza, Ph.D., local Statistics Consultant to HKI for several years, provided advice on the baseline survey design.
d. The Institute of Training, Evaluation and Research provided staff assistance to train survey interviewers and collect data.

Analysis and Application of Qualitative Data:

Kirsten Laursen, MA, Director of Training and Community Education, HKI New York, provided advice on analyzing the data from the qualitative RAP survey and using the results to develop new modules for the Child Growth Basic Learning Package, provincial communications plans and IEC materials. She also co-facilitated a workshop to review communications materials.

2. Desired technical support - HKI Philippines' introduction to the MTE team included a request to them for technical assistance in developing indicators for monitoring the results of CSX's advocacy efforts in affecting LGU political policies and processes regarding nutrition issues at the provincial and municipal levels and how these issues are manifested at ***the barangay*** level. These multi-level process indicators were not present in the DIP, which focused on indicators of the household-level behavior changes expected by the end of the project. HKI also requested assistance in developing a monitoring plan for these new process indicators, e.g., who would monitor? how often? where? using what sources? and how would the data be analyzed and subsequently used? A list of suggested process indicators which was presented by the MTE team to HKI Philippines during the debriefing session is found in Appendix 6.

Subsequently, during the MTE, the idea of modifying the Provincial Task Force's roles and goals was raised and selected techniques from Total Quality Management **(TQM)** methods were recommended (Recommendation II A). In order to support these new activities required for team-building and developing effective provincial and municipal managers of nutrition programs, the Area Coordinators feel that it is necessary for them to participate in the process first as peer members of the PTFs and then they can assume greater responsibility with the remaining PTFs as they gain confidence. All members of the CSX field and Manila staff can benefit from developing selected TQM skills to complement their current depth of training, communications and process skills. A training package of three

manuals from Cornell University's Community-Based Nutrition Monitoring Project has now been supplied to I-W/Philippines to provide an introduction to TQM methods, advocacy, coalition building and communications.

J. Assessment of Counterpart Relationships

At the national level, HKI's operational counterparts are members of the National Nutrition Service and National Nutrition Council. Among the major areas of collaboration are support for ASAP, development of nutrition materials and staff training.

The chief counterparts for this project at the LGU level are the eight Provincial Task Forces whose members generally represent: the Department of Health (Provincial Health Officers), Office of Provincial Agriculture; the Department of Education, Culture and Sports; the Provincial Nutrition Office; the Provincial Planning and Development Office; the Philippines Information Agency (Provincial Officer); the Department of Interior and Local Government; and Provincial Governor.

Current activities with these counterparts and recommendations for the future are discussed in section VI A. As assessed by the MTE team, HKI's counterpart relationships with the CSX project are considerably extensive, productive and mutually respectful. The challenge now is to extend these relationships for the development of municipal-level task forces.

K. Referral Relationships

Identification of referral care sites and access and service quality are not a priority of this project yet. It will become more of a priority as soon as the **RHMs** complete the mothers' classes which are currently underway.

L. PVO/NGO Networking

Given HKI's organizational role as a provider of technical assistance, networking with others is an absolute necessity which HKI Philippines takes very seriously. There are no other USAID/BHR/PVC-funded Child Survival projects in the Philippines nor are there any major PVO (Private Voluntary Organization) or NGO child survival projects in HKI's CSX areas. At the time of providing orientations to local counterparts about CSX, HKI invited those **PVOs** which had a presence in the area (Catholic Relief Services [CRS] in E. Samar and CARE in S. Leyte and E. Samar.

Prior to CSX, HKI worked with CARE to develop a package of participatory activities for midwives to use in communicating to mothers about VAD-IDA-IDD (vitamin A deficiency; iron deficiency anemia; iodine deficiency disorders). This kit, called FLANE (Fun Learning Activities for Nutrition Education), is used by **RHMs** who have been trained by CARE in E. Samar and S. Leyte. Up until June 1996, when CARE's nutrition assistance terminated, CARE and HKI co-invested in these training events.

HKI's collaboration with CARE on the FLANE Kits was part of HKI's VITAP project implemented in the Philippines from 1990-1994. The objective of VITAP was to increase

PVOs' commitment to addressing vitamin A deficiency and this mandate was extended to local NGOs through HKI's companion Project MATA. CARE, CRS, Save the Children and the Adventist Development and Relief Agency (ADRA) were among the collaborating partner organizations in VITAP which, encouraged by HKI, all recently joined a newly-organized coalition of Nutrition NGOs (KAIN) in the National Capital Region. HKI currently serves as the secretary. Region VI has a similar coalition called KAPAWA.

One situation which may have an effect on CSX in S. Leyte and E. Samar is that CARE and CRS will be terminating their PL480 Title II food aid assistance within the next year. The disadvantaged families which have been recipients of this food aid are also the families which HKI aims to assist through CSX. Given the tendency of political figures and many health providers to define a "nutrition program" as Title II foal assistance, it is interesting to speculate what these individuals will define as a "nutrition program" in the absence of these free food supplements which have been available in the Philippines for two to three decades.

The impact of terminating foreign food aid could be positive, if the Provincial Task Forces and their like-minded nutrition allies can help LGU officials to understand and promote the broad range of cost-effective interventions which can have dramatic positive effects on nutrition, without having to provide food supplements directly to malnourished individuals. These nutrition interventions include: exclusive breastfeeding, appropriate weaning practices with locally available and affordable foods, micronutrient supplements (vitamin A, iron and iodine for vulnerable groups), good prenatal care, case management of diarrhea and acute respiratory infections and identification of growth faltering and appropriate nutrition counselling for children under two. Just as important as these latter interventions *per se* are other interventions (such as CSX) which focus on capability building for improving the systems that deliver these health services and messages to mothers of preschool children.

M. Budget Management

UNICEF contributes financial support to four of the eight provinces for training of midwives and BHWs, as well as printing of all the Child Growth Basic Learning package materials. During the MTE, HKI field staff predicted that some UNICEF-funded training events were going to be delayed. In these provinces, LGU officials had not submitted financial reports for other, non-HKI-related activities, and thus the next dispersement of UNICEF funds for the entire province is contingent upon "liquidation" of these reports. HKI needs to discuss possible mechanisms whereby its training events are not negatively affected by LGU reports for other activities (Recommendation VIII A).

HKI anticipated contributing vitamin A capsules to this CSX project as part of the PVO match (estimated @ $30,000). However, UNICEF has supplied all the necessary capsules to date and therefore HKI will provide this match from another source. At the time of the MTE, the field budget was underspent by approximately 74% (see Pipeline Analysis in Appendix 12). Fairly significant savings occurred during Year 1 due to co-sharing with the UNICEF-funded Child Growth project. The types of recommendations being made by the MTE team may necessitate shifts in the budget, e.g., for team-building exercises with the PTFs, for unanticipated training of PHNs, increased staff and/or improved communications hardware and software for the Area Coordinators. The HKI Philippines staff is planning an

internal project review session immediately following the MTE team's visit. Any needed changes in the budget which arise from that meeting will be discussed with HKI New York, USAID Philippines and USAID Washington. If there are expectations that the budget will be underspent by the end of Year 3, HKI will consider requesting a no-cost extension. Conclusions reached about the budget remaining to finish Year 2 and for Year 3 will assist HKI in considering various options for continuing this CSX project beyond Year 3 (Recommendation VIII B).

VII. SUSTAINABILITY

The CSX project is contributing to sustainability on a number of levels. On the national level, efforts to support the National Nutrition Service and the National Nutrition Council to creatively work with the challenges of devolution will enable these key nutrition organizations to move forward and more effectively address issues such as the distribution of vitamin A capsules during and after national micronutrient days, development of the National Micronutrient Operations Plan, and the general areas of advocacy and training of nutrition staff.

On the provincial level, establishment of the PTFs, which are linked to the National Nutrition Council, are now reactivated and function to better coordinate nutrition activities at the provincial and municipal levels. During the MTE, HKI made a strategic decision to associate the PTF and the municipal task forces (to be created and/or reactivated in the near future) with the NNC. This has obvious advantages for sustainability: the NNC is a known quantity that has existed for more than 20 years, it is not a new creation although some new members have been added to the PTF; it will be less likely to be associated with HKI which may leave the province once the project has ended; and it has the potential to be a crucial decision-making body at both the provincial and municipal levels. In addition, the advocacy, planning and coordination roles of the task force model could 'go to scale' since nutrition committees exist (with varying levels of activity) throughout the country.

Once development of a truly integrated plan of action for nutrition becomes routine, as does monitoring and reporting of essential health and nutrition data, HKI will have made a major contribution to the development of a sustainable system in those provinces. The challenges remain, however maintaining adequate program funding levels, particularly for the less populated and generally poorer provinces. There are already promising signs that the advocacy work of the PTFs is paying off -- the examples previously mentioned where one governor pledged significant funds for nutrition for his province (S. Leyte) and a key PHO changed his perceptions about the magnitude of malnutrition in his province after seeing the facts in ***the Health and Nutrition Situation Report,*** paving the way for changes and prioritization of nutrition programs.

Given devolution of the health system in the Philippines, establishment of a solid and effective task force which brings to light maternal and child nutrition issues is almost essential for sustainability. There is a true concern that if no force is motivated to address these issues in a municipality or province where the LGU has other priorities, the health and nutrition situation may deteriorate.

HKI developed quality training for the PTF, RHMs and BHWs to strengthen their skills and transfer them back to their place of work and to those whom they will train and/or counsel in the future. For example, each PTF member interacts with many other colleagues besides those on the PTF. Likewise, the RHMs can use their new skills in participatory learning with interactions they have with mothers outside the mothers' class. For their part, many BHWs *wear several* 'hats' in *the barangay,* e.g., as community agricultural or family planning agents, and they can implement their counselling skills in other interactions with friends and neighbors. Training events (Appendices 7 and 8) and accomplishments to date in Section III document the concrete steps HKI is taking to assure sustainability of key project innovations.

One area which is unlikely to be sustainable on a long-term basis, however, is for the PTF to train BHWs. It is also difficult to see this model as 'going to scale'. As previously noted in Section D, a provincial-municipal health training team should be developed during the next phase of this project as trainers of the BHWs and also serve as monitors for the *barangay*-level interventions. In addition, the recommendation for orienting and training nurses in the CGP and in monitoring will help ensure sustainability as they are the established supervisors of the RHMs.

VIII. CONCLUSIONS AND RECOMMENDATIONS

The data gathered and analyzed by the MTE Team leads to three overall conclusions about HKI's CSX project. The major recommendations which stem from these conclusions are presented in sections I-IV which follow. Supporting recommendations are found in sections v - VIII.

CONCLUSIONS

Overall Achievements: This project is atypical for the Child Survival Program and represents fairly "unchartered waters" for U.S.-based PVOs such as Helen Keller International. The LGU system in the Philippines now mandates that NGOs interested in health [and any other issue] learn how to negotiate through the newly-organized political bureaucracy at different levels. Eight Provincial Task Forces have been formed and energized as a focus for advocacy and action. The strategy of working with PTFs is teaching HKI and the PTF members the necessary steps which must be taken to work within the LGU system and the time and flexibility necessary for each step in each province. HKI's CSX project is meeting this challenge and making remarkable progress so far. In the months to come, this process will be applied to the municipal level.

Project Design: This project has two major components: national level (dealing with policy) and provincial level. The latter is broken into two prongs: policy and planning with LGUs (via the PTFs) and working directly with health providers (RHMs, BHWs) to change nutrition and health behaviors at the household level. Each of the two provincial prongs requires a different package of skills and activities. Currently, HKI is managing these two together through the activities of the Area Coordinators, the only HKI staff with regular presence at the provincial level. Results will be limited due to the merged concepts of the two prongs, current design weaknesses in each prong, and the insufficient human resources.

Project Objectives: HKI will not be able to achieve the community-based behavioral objectives as listed in the DIP due to: initial delays in the project; the merged prongs of implementation at the provincial level; the possibility that PTFs will lose enthusiasm if not reorganized; the need to apply much more intensive follow-up to the RHM training (as they ***take the CG package*** out ***to the barangays*****),** and the projected need to do the same once the **BHWs** get trained; and the need for close monitoring of what is happening at the community-level to permit modifications along the way.

RECOMMENDATIONS

I. Project Objectives and Interventions

A. Reduce scope and refine interim objectives

1. Reduce number of provinces where work is intensive and focus on four or five with the most potential (e.g., Samar, S. Leyte, Biliran, Masbate, Albay);

2. Select one or two key interventions to tackle per province, such as salt iodination in Biliran and Masbate, iron supplementation in Leyte, increased VAC coverage in Albay, etc. . . Do not plan to implement the whole package in all eight provinces;

3. Develop province-specific indicators for the chosen interventions, including any of the relevant and viable household behavioral change indicators in the project's DIP objectives; and

4. From now on, and for the Final Evaluation, consider each province as its own unit of measurement, using provincial-specific indicators and modify the Baseline Survey accordingly for the Final Evaluation. Do not repeat the Baseline Survey as currently designed until there are sufficient community-level interventions underway to effect household behavioral changes in the eight provinces. These changes in practice may not be widespread at all within the life of the current CSX grant.

B. Evaluate options for the next phase of this project, taking into account the possibility of a no-cost extension (several months) of CSX, the life of the Child Growth Project, and coordination with the funding cycles of potential funders, e.g., corporate, private, bilateral, multilateral. For example,

1. Apply for a no-cost extension (of several months) for CSX, then apply in December 1996 for CSXIII, incorporating the extension into the new start date; or

2. Apply for a no-cost extension (of several months) of CSX and find other funding sources to complete FY'97; apply in December 1997 for CSXIV; or

3. Consider other scenarios besides USAID/PVC/Child Survival, e.g., USAID/Philippines or a combination of local and international donors

II. Task Forces

A. Provincial Task Forces - Plan an additional workshop with each PTF to discuss Task Force identity, mission, focus of activities, follow-up communications plan with LGUs, roles of individual members, monitoring schedule and identification of promising municipalities to work with for the remaining time of CSX. Consider external technical assistance to lead HKI through this process with one or more PTFs until HKI staff gained the skills necessary to manage this alone.

B. Advocacy Events - Consider the suggestions provided by the MTE Team for making these more directed to the audience and more participatory (based on observations of the Advocacy Forum in Malitbog, S. Leyte and the Salt Forum in Naval, Biliran).

C. Municipal Task Forces - Create municipal-level Task Forces in a few select and promising municipalities using the PTF members to identify these places and to "reactivate" the Municipal Nutrition Committees.

HI. Training of Health Providers

A. Training of BHWs - Find and orient additional trainers for the BHW training (since it is just commencing), preferably drawing from the municipal-level health staff to complement the PTF health trainers. Release the non-health PTF members from further training responsibilities and redirect their focus to advocacy, monitoring and communications.

B. Training of RHMs - Incorporate the concept of their role as 'team leader' in the community and the need for them to call on other community leaders to help promote the Child Growth messages. Identify several RHMs who already exhibit these qualities, provide them support and monitor behavior change at the household level in the ***barangays*** under their responsibility.

C. Training of Public Health Nurses - Design a brief orientation workshop for municipal PHNs in the HKI-focused ***barangays.*** Have PHNs involved in supervision and monitoring of training done by RHMs, use of Counselling Cards by BHWs and application of these efforts by mothers in the household.

Iv. Monitoring

A. Process Indicators

CSX staff should use the draft list of indicators (Appendix 6) to develop a set which can be used to monitor critical processes and achievements at the LGU level. Given the diversity of needs and accomplishments to date in each province and the inadvisability of trying to implement the complete package of interventions in all eight provinces, the indicators for each province should be tailor-made. Some will be uniform, such as indicators of the

functioning of the PTF; others will be specific, such as activities to promote the availability and consumption of iodized salt.

Use a checklist of process indicators for steps that need to occur before household behaviors can be changed, e.g., iodized salt needs to be available first in the markets and/or through the health system before households can increase their use; VACs must be available in the clinics before RHMs and BHWs can refer cases.

B. Qualitative Documentation of the Project

Reporting of successes, examples of accomplishments and progress indicators needs to be done more systematically and routinely. HKI should try to better document its accomplishments, for example,

- establish progress monitoring forms based on process indicators in Appendix 6;
- examples of successes need to incorporated into the ACs' monthly reports;
- in written reports, be sure to quantify the number of workshops or consultative meetings; do not assume that the reader knows that one event is being repeated in two, four, six or eight provinces;
- when quantifying materials, specify # copies to # provinces in #___ languages!
- make it easy for anyone to contributeinformation to this database, for example, set up a folder on someone's desk marked "Child Survival Stories" and put pieces of information in it, even just short hand-written reminder notes taken during a field trip or a meeting when one of these stories comes up

C. Implementation of the Monitoring System at the Provincial, Municipal and *Barangay* Levels

Develop monitoring systems for specific project activities which are being implemented at the provincial, municipal and *barangay* levels. Determine what will be monitored, using which indicators, who will do the monitoring, how often, using which tools, and what will happen with the data once collected.

V. Human Resources

Funds permitting, recruit and train a staff assistant for the Area Coordinators and/or consider providing them with cell phones to improve communications during travel and to maximize their efficiency. One Coordinator needs a computer and printer and the other needs this her equipment upgraded.

VI. Materials and Supplies

A. Develop more advocacy materials for use by PTFs and others for nutrition and health promotion to various levels and representatives of the provincial and municipal LGUs.

B. Cancel plans to create a national nutrition newsletter for LGUs.

VII. Supervision

A. Supervision plans (who, what, where, when, how often) need to be developed for PHNs to monitor RHMs and for PTFs and RHMs to monitor BHWs

B. Follow-up Training - After each RHM or BHW training, there should be a planned Feedback Seminar (approximately 1/2 - 1 day long) six months later (to discuss how things are going) and a Refresher Training 12 months later for the trainers to go over weaknesses and develop strategies for overcoming difficulties they have observed.

VIII. Budget Management

A. With UNICEF - Work out an acceptable payment schedule from UNICEF to HKI in the four Child Growth provinces so that CSX progress is not hampered due to delays in LGU submission of financial reports to UNICEF (called "liquidation").

B. Revisions of budget after MTE: CSX management staff need to estimate the impact on the budget of any modifications planned for this project as of the MTE. Any major budget changes will need to be discussed with HKI New York and approved by USAID Washington. Based on this budget analysis, HKI Philippines should begin to identify funding options for continuing this project.

Itinerary of Mid-Term Evaluation Team
August 3 - 16, 1996

Date	Time	Itinerary/Activities	Persons Contacted
August 3	a.m	HKI: Briefing and orientation on itinerary	• Rolf Klemm • Ellen Villate • Daylyn Sandrino • Eva Puertollano • Chato Lopez • Emy Garma • Berna Ungson • Cecille Lim
August 5	a.m.	Travel to Cebu	
	p.m	Travel to Maasin, Southern Leyte	
		Meeting with Prov'l Tash Force	• Dra. Asperin - PHO • L. ran • V. Manlimos • N. Rich • R. Cadavos • N. Gomez
		Travel to Malitbog, Southern Leyte	
August 6	a.m.	Advocacy Forum for Nutrition with Mayors (Malitbog. So. Leyte)	• Gov. Dr. 0. Tan • Ma!-or G. Yong/Sogod • Mayor A. Escano/TomasOppus • Members of PTF • Dr. R. Briones - NNC
	p.m.	Travel to Tacloban • Courtesy call PIA	• Ms.A. Candid0 - PIA
August 7	a.m.	Travel to Eastern Samar	• E. Grande - Reg. Health Office. Reg. Nutritionist • A.Querol -HKI/Area Coord.
	p.m	• Courtesy call - Go\-emor/PHO	• Dr. H. Macapanas - Prov.Health Officer • Assistant PHO • M. Domingo - Exec. Assistant
	pm.	• Meeting with Provincial Tash Force	• A. Action -DA • A. Nicart - PIA • L. Dotingco- PHO • D. Dorado
		• Field visits for Mother-s Class	• Midwife (1) • BHW (4) • Mothers

August 8	a m.	Travel to Tacloban	
		• Courtesy call - Regional Health Office	• Dr. A. Perez - Regional Health Office (RHO)
	p.m.	• Field visits for Mother's Class in Tanauan. Leyte	• Midwives (6) • BHWs (3) • Mothers
		• Meeting with Provincial Task Force	• E. Martin - PPDO • J. Egay - PHO • V. Femandez -PHO • B.Garido - POPCOM (PNAO)
4ugusl 0	a.m.	Travel to Biliran	
		• Courtesy call - Governor/PHO	• Go\-. Wayne Jaro • Dr. J. Pastor - PHO
		. Meeting with Prov'l. Task Force	• Dr. Cotiangco - Asst. PHO • Ms. Sde 10s Santos - DECS • Ms. C.Gabucan - PHO • Ms. G. Roa - DILG
		• Salt Forum	• F. Montiveros - KAKASAKA Fdtn (Salt Producer)
	p.m.	Travel to Tacloban	
August 10	a.m.	Travel to Manila	
	p.m.	Report Writing	
August 11	Report Writing		
August 12	a.m.	• Courtesy call •National Nutrition Council	• B. Flores - Dep. Dir. for Operations
	p.m.	• Courtesy call ● DOH - Secretary •DOH - Nutrition Service	• Ms. Reodica • A. Ramos
August 13	a.m.	Travel to Masbate/Albay	Masbate/Albay
	p.m.	• Courtesy call - Governor/PHO	•Governors •PHOs
		• Meeting with Provincial Task Forces	
		• Field visits - Conduct of Mothers Class/ Home Counseling	RHWs (midwives) BHWs Mothers
August 14	a.m.	Travel to Manila	
	p.m.	Report Writing	

Date	Time	Itinerary/Activities	Persons Contacted
August 15	a. m	Courtesy call lo US AID	• M. de Sagun - Prog. Coor. Specialist/Nutrition • Dr. C. Carpenter-Yaman - Office of Population. Health & Nutrition
	p.m.	WRITE -UP	
August 16	WRITE - UP Debriefmg HKI		
August 17	DEPARTURE		

SECTION C.2 TABLE B: PROJECT GOALS AND OBJECTIVES

PROJECT GOALS:
1. To reduce morbidity, mortality, and disability among women and children resulting from PEM and micronutrient malnutrition.
2. To strengthen community-based interventions improve breast-feeding, complementary feeding, and consumption of micronutrient-rich foods or supplements

(1) **Project Objectives by**	(2) Measurement Method	(3) **Major Planned Inputs**	(4) **outputs**	(5) **Measurement** Method
reduce by 10%, the prevalence of weight-for-age below - 2 z scores from the WHO/NCHS median reference among infants and children younger than 24 months old	baseline and endline survey on weight-for-age	. train health workers to promote beneficial breast-feeding & complementary feeding practices . promote growth through various media channels . procure scales and growth charts from DOH & UNICEF . produce promotional materials on breast-feeding & complementary feeding	. number of *barangay* weighing posts established • number of health workers trained to promote growth • number of functional scales available at weighing posts . quality and quantity of promotional materials produced	. review accuracy of weight & counseling advice recorded on growth monitoring cards . pre/post training evaluation of health worker skills . supervisoty reports on equipment . waluation of materials & messages
increase by 10%. the proportion of infants (6-l 1 months old) who consume only breast milk until they were 4 months old	baseline & endline survey	. train health workers to promote exclusive breast-feeding . promote breast-feeding through various media channels . produce promotional materials on exclusive breast-feeding	• number of health workers trained to promote exclusive breast-feeding • quality and quantity of promotional messages 8 materials produced	. review accuracy of counseling advice recorded on growth monitoring cards . pm/post training evaluation of health worker skills . supervisoty reports on observation of health worker skills . evaluation of materials & messages

SECTION C.2 TABLE B: PROJECT GOALS AND OBJECTIVES (continued)

(1) Project Objectives by	(2) Measurement Method	(3) Major Planned Inputs	(4) outputs	(5) Measurement Method
increase by 10%, the proportion of infants (6-l 1 months old) who start to consume the 'Weaning Mix" when they are 6 months old	baseline & endline survey	. train health workers to promote the introduction of the 'Weaning Mix' at 6 months . promote the 'Weaning Mix" through various media channels . produce educational materials on the 'Weaning Mix'	. number of health workers trained to promote exclusive breast-feeding . quality and quantity of promotional messages & materials produced	. review accuracy of counseling advice recorded on growth monitoring cards . pre/post training evaluation of health worker skills . supervisoty reports on observation of health worker skills . evaluation of materials & messages
increase by 10% the proportion of infants (6-l 1 months old) who consumed the 'Weaning Mix' at least three time in the last 24 hours	baseline 8 endline survey	. train health workers to promote frequent feeding of the *Weaning Mix' . promote the 'Weaning Mix" through various media channels . produce educational materials on the 'Weaning Mix'	. number of health workers trained to promote exclusive breast-feeding . quality and quantity of promotional messages & materials produced	. review accuracy of counseling advice recorded on growth monitoring cards . pre/post training evaluation of health worker skills . supervisoty reports on observation of health worker skills . evaluation of materials & messages
increase by 10%, the proportion of children (12-23 months old who still breast-feed)	baseline & endline survey	. train health workers to promote prolonged breast-feeding . promote prolonged breast-feeding various media channels . produce educational materials on prolonged breast-feeding	. number of health workers trained to promote prolonged breast-feeding . quality and quantity of promotional messages & materials produced	• review accuracy of counseling advice recorded on growth monitoring cards • pre/post training evaluation of health worker skills • supervisoty reports on observation of health worker skills • evaluation of materials & messages

SECTION C.2 TABLE B: PROJECT GOALS AND OBJECTIVES (continued)

(1) Project Objectives by	(2) Measurement Method	(3) Major Planned Inputs	(4) outputs	(5) Measurement Method
maintain on-time vitamin A capsule coverage at 50% of preschool children (12-59 months old) who live In communities where food frequency scores indicate continued risk of VAD	baseline and endline surveys of vitamin A capsule coverage and of food frequency scores using HKI-FFM	. procure vitamin A capsule supply from Nutrition Service . train health workers . develop promotional materials for National Immunization and Micronutrient Days	. supplies of vitamin A capsules available in Health Centers . number of health workers trained to administer vitamin A capsules . quality 8 quantity of promotional materials	. review of monitoring reports on vitamin A capsule supplies . pre-post training evaluation of health worker skills . review of monitoring reports on vitamin A capsule supplies . evaluation of materials & messages
increase consumption of vitamin A-rich foods among preschool children (12-59 months old) until at least 67% of communities have average food fequency scores that are significantly above the HKI cutoff valus for risk of VAD	baseline and endline surveys of food frequency scores using HKI-FFM	. procure vitamin A capsule supply from Nutrition Service . train health workers . develop promotional materials for National Immunization and Micronutrient Days	. number of health workers trained to promote vitamin A-rich foods . quality 8 quantity of promotional materials	. pm-post training evaluation of health worker skills . special monitoring study on availability of vitamin A-rich foods . evaluation of materials & messages
reduce by 10%, the total goiter (palpable plus visible) rate among *married* women of child-bearing age(15-40 years old)	baseline and endline survey palpating goiter	. procure iodized oil capsules from NS or local government . train health workers to administer iodized oil to women of child-bearing age in endemic areas . develop promotional materials for National Immunization & Micronutrient Days	. iodized oil capsules available at health centers . iodinated salt available at the household level . health workers trained to administer capsules and counsel women . number & quality of promotional materials produced	. monitoring report on iodized oil supplies . pre-post training evaluation of health workers . review of promotional materials & messages

SECTION C.2 TABLE B: PROJECT GOALS AND OBJECTIVES (continued)

(1) Project **Objectives by**	(2) **Measurement Method**	(3) **Major** Planned **Inputs**	(4) **outputs**	(5) **Measurement Method**
increase by **20%,** the proportion of households that use iodinated **salt where** it is available	baseline and endline survey on iodinated salt using UNICEF test kits	train health workers to promote iodinated salt where it is available . develop promotional materials for National Immunization & Micronutrient Days	. iodinated salt available in stores . number of health worker? trained to promote iodinated salt . number & quality of promotional materials produced	. monitoring report on iodinated salt supplies • pre-post training evaluation of **health** workers . review of promotional materials & messages
reduce by **10%,** the prevalence of low hemoglobin concentration (cl 1 **g/dl**) among women of childbearing age (1540 years old)	baseline and endline survey using hemoglobinometer	• procure iron folate tablets from UNICEF, NS or local government • train health workers to administer iron folate tablet to pregnant women • develop promotional materials for National Immunization & Micronutrient Days	. iron folate tablets available at health centers . number of health workers trained to administer iron tablets and counsel pregnant women . number & quality of promotional materials produced	. monitoring report on iron folate supplies • pre-post training evaluation of health workers . review of promotional materials & messages
increase by **20%,** the proportion of pregnant mothers who begin to take iron supplements by the fifth month of **pregnancy**	baseline **and** endline survey	• train health workers to administer iron folate tablet to pregnant women from the fifth month of pregnancy • develop promotional materials for National Immunization & Micronutrient **Days**	. iron folate tablets available at health centers . number of health workers trained to administer iron tablets and counsel pregnant women . number & quality of promotional materials produced	• pre-post training evaluation of health workers . review of promotional materials & messages

SECTION C.2 TABLE B: PROJECT GOALS AND OBJECTIVES (continued)

(1) Project Objectives by	(2) Measurement Method	(3) Major Planned Inputs	(4) outputs	(5) Measurement Method
increase by 20%, the proportion of pregnant women who continue to take iron supplements on a daily basis for a least 2 months during the latter two trimesters of pregnancy	baseline and endline survey	. train health workers to counsel pregnant women to continue taking iron folate tablets . develop promotional materials for National Immunization and Micronutrient Days	. number of health workers trained to administer tablets & counsel women . quality & quantity of promotional materials produced	. pre-post training evaluation of health workers . evaluation of materials & messages

APPENDIX 3

TABLE 1: CHILD SURVIVAL ACCOMPLISHMENTS TO DATE (JULY, 1996)

CSX ACTIVITIES FROM OCT. 1994 - SEPT. 1997	ACCOMPLISHMENTS AS OF JULY 1996	REMARKS
A. Pre-Implementation		
I. Finalization. approval and signing of the Grant Agreement	Completed	This was done with USAID/ Washington and HKI/NY
Selection of Child Survival Areas - 8 provinces	Child Survival is being implemented in 8 provinces in 2 regions: *Region V - 2 provinces *Region VIII - 6 provinces	Masbate and Albay, N. Leyte, S. Leyte, Biliran, N. Samar, E. Samar & W. Samar
Hiring and Selection of 4 Project Staff	Hired 2 Area Coordinators	The Program Manager and and Driver with 100% project involvement were already in place at HKI
Meeting orientation with Various DOH services * Maternal & Child Health * Nutrition Service	Meeting orientation were Conducted not just with DOH but also with other Government organizations and NGOs who are involved in nutrition like the Nat'1 Nutrition Council UNICEF and KAIN	
Preparation and submission Of Detailed Implementation Plan	Submitted the draft DIP To HKI/NY (211995)	HKI/NY submitted the DIP To USAID/Washington (3/1995)
Orientation meetings with Governors in 8 provinces	Orientation meetings were conducted with the Governors in 8 provinces.	
Organization of the PTF In each province	Organized 8 PTFs.	
B. Local Government Units Component		
1. Community Assessment		
Conduct Workshop on the Development of Assess-ment Tool	Conducted one workshop for 4 provinces (Masbate, Albay, Leyte and Eastern Samar) date?	The original design was to conduct this training in 4 provinces (4 CG/CSX areas). These development tools were used in conducting qualitative study

Activities	Accomplishments	Remarks
		which served as input in developing the Basic Learning Package
Conduct of KAP Formative Survey (qualitative study)	Conducted in 4 provinces (Masbate, Albay, Leyte and Eastern Samar)	See above
Workshop on the assessment of the Provincial Health and Nutrition Situation.	Conducted in 4 provinces for the first round. Developed 8 Provincial Health and Nutrition Situation Report (July 1996)	Details in Training Table # 5 - 1, 2, & 8 Appendix 8 Assessment of the Health & Nutrition Sit. in the remaining 4 provinces was incorporated into the training (as part of the design) Appendix 8 , #8.
Data analysis and Interpretation.	Conducted the CSX - Nutrition Intervention Plan ning Workshop for eight provinces.	During this workshop, the re suit of the baseline survey was presented and analysis of existing nutrition date were reviewed. Detailed information in Appendix 8 - #8
Training Needs Assessment Workshop	Conducted one workshop for four provinces (Masbate, Albay, Leyte & Eastern Samar)	Detailed information in Appendix 8 - #6
Conduct of the Baseline Survey	Conducted in all 8 provinces	Detailed information in the Baseleine Study of the briefing kit.
2. Advocacy and Planning		
Conduct of Planning Workshop.	Conducted 8 planning workshop/meetings in 8 provinces. Developed 8 Provincial Nutri- tion Action Plans.	Details in Appendix 8 - #9
Conduct Communications Planning Workshop	Conducted one workshop on communications planning in 4 provinces (Masbate, Albay, Eastern samar & Leyte) Developed and formulated 4 Communications Plan for 4 provinces (Albay, Masbate, Eastern Samar	Details in Appendix 8 - #3

Activities	Accomplishmnts and Leyte)	Remarks
3. Training		
To conduct the folloning trainings/workshops: * Start-up orientation * Follow-up workshop on the Prov'l. Health and Nutrition Situation Report. * Workshop on the Dev. of the Basic Leaming Package. * Training of Trainers on the Use of the Basic Learning Package * Planning Workshop * Workshop on Nutrition Program Advocacy for Local Government Units (for PTF and Prov'l. Nut. Committee)	Conducted the following workshops/trainings (dates?) /	Detailed information of all trainings/workshops conducted **can be** found in Appendix 8
Training o f Community Volunteer Health Workers on Counseling Skills using the Counseling Cards (16 groups of 25-30 CVHWs/ group)	Conducted 3 Community Vol unteer Health Workers trainings (dates?)	Details in Appendix 8 - # 13 Remaining 13 groups will be completed by October 1996
Training of RHMs in conducting Mothers classes on the Use of the Basic Learning package (11 groups of 20-30 midwives per group)	Conducted **8** RHMs trainings (Dates?)	**The remaining 3** groups will be completed by 9/1 996. Details in Appendix 8 - #11
Establish one core training team:HKI staff and DOH Regional and Provincial.	Estab. 2 levels of CORE Training Team. *National Level - HKI, NS, NNC and MCH *ProvincialLevel-PTF	
Training of Nurses on Basic Learning Package & Supervision.	To be done (TBD)	This training was initially planned, then aborted. The MTE recommends this training be reinstated as planned.
VAD-IDA-IDD Case Detection Treatment and Mgnt.	(TBD)	
Bio-lntensive Gardening Training	(TBD)	
Monitoring and Evaluation	not conducted yet	

Activities	Accomplishments	Remarks
4 Community Interventions		
Distribution of Child Health Package to the province - Basic Learning Package * Reference Guide * Training Activities * Counseling Cards * Comics - 5 series	Distributed the following Child Health package to the 8 provinces: * 600 Reference Guide * 600 Training Activities * 150 Counseling Cards * 300 Comics - 4 series Other materials distributed to the provinces * 5.000 ASAP '95 Flyers *5,000 ASAP '95 Volunteers Guide * 1 .OOO Reference Posters	*Note: Funds for the Child Health Package were taken not from the CSX funds* Distribution will be completed once the training of RHMs and VHWs is completed. Printing of comics is on-going
Airing of radio plugs and showing of video tapes	Developing radio plugs Distributed 3 video tapes on Ending Hidden Hunger and VAD-IDA-IDD Case Detection and Management to one province	Based on the provincial plans developed, only 4 provinces need video tapes.
Intensify village based services * counseling, mother support group. village weighing post and growth monitoring	Mothers class, village health station and growth monitoring commenced at community level.	Counseling and establishing of village weighing post will be operational once all the trainings for the Village Health Workers will be completed (October 1996 j.
Specific Community Based i&mentions (based on the specific need of the province)	Community Based Salt Monitoring Using Lot Quality Assurance in 4 out of 5 targeted provinces.	One provincial orientation on CBSM-LQAS August 1996.. * 2 Provinces- CSX sponsored completed * 2 Provinces - UNICEF - sponsored - TBD
	Conducted a Salt Forum with Dealers, Salt Producers Cooperative, Women's Group, Schools, Cafeteria, BHWs	Forum goals are to help in making connections i n bringing iodized salt into the province and eventually in the municipality.

Activities	Accomplishments	Remarks
5. Monitoring		
Monitor conduct of provincial and barangay level trainings	All Midwives and Village Health Workers trainings conducted were monitored by HKl.	
* 1 I RHMs Trainings	* RHM - 8 out of 11	
* 16 VHWs Trainings	* VHW-3outoflG	
Periodic monitoring of mothers classes/counseling.	Underway and will propose developing monitoring plan and/or forms	
Consultative meeting with Trainers for the re-training of implementors	To be done by Aug./Sept. of 1996	Due to the delay of the schedule of activities, retraining activities will be conducted during the 1 st or 2nd quarter of 1997.
Retraining of the implementors	To be conducted on the 4th quarter of 1996/ per schedule	
Monitor conduct of retraining of implementors	To be conducted on the 4th quarter of 1996/ per schedule	
Conduct of pre-post assessment during training	Re-post assessment are conducted in most of the trainings	These served as basis in improving contents and methodologies for succeeding trainings.
Conduct of special monitoring studies to assess the progress o f community based interventions.	-To be conducted by the 4th quarter of 1996.	To be completed EOP
Routine monitoring	Monthly meetings of Project staff Quarterly Consultative Mtg. with Prov'l. Task Force.	2 Consultative meetings conducted to date
Submission of reports		
* Monthly - April 1995 to Sept. 1997	Submitted monthly reports for: * Oct. 1994-March 1995-consolidated * April 1995-July 1996 (monthly)	
* Annual Report	* 1st Annual Report submitted Oct. 1995	

Activities	Accomplishments	Remarks
6. Evaluation		
Develop an annual State of Nutrition report and documentation of lessons learned.	Developed the Provincial Health & Nutrition Situation Repon in all 8 provinces (July 1996)	
	Conducted Advocacy Forum on Nutrition for Mayors	Goal is for Health & Nutrition reports tobe used for lobbing for increased local resources for nutrition from local budgets.
	Lessons learned were docu mented and were included in the 1 st CSX Annual Report.	
Conduct of Mid-Term Eval.	August 1996	
Conduct of Final Eval.	3rd quarter of 1997	
Presentation of Evaluation Findings	4th quarter of 1997	
C. National Nutrition Service Component		
1. Advocacy - work with NS to produce materials to excite: inform and mobilize LGU support for micronutrient interventions.	Conducted workshop on Nutrition Program Advocacy for Local Govt. Unit (for the entire National Nutrition Service staff - June, 1996)	
	Develop Advocacy Package for Nutrition Service and LGUs - draft completed / August 1996.	
2. lrnplement ASAP		
Development of Field Guide for the National Micronutrient Campaign	Produced 5,000 copies of ASAP '95 Volunteers Guide	Update the 1994 HKI developed ASAP materials
	Produced 5,000 copies of ASAP '95 Flyers	
Assist NS to design and conduct Post ASAP coverage survey.	Provide technical assistance in the conduct of the Post-ASAP coverage survey.	
3. Review the National Program (Micronutrient Program)	Provided on-going support for the development of National Micronutrient Program.	On-going activity

Activities	Accomplishments	Remarks
Conduct a National Policy and Program Review	Assisted the Dept. of Health in reviewing and integrating the existing policy on Child Development of Maternal & Child Health & the Nutrition Service.	
4. Share Technology		
Organize symposia for LGUs & NGOs to show-case appropriate technologies to prevent micronutrient malnutrition, promote linkages & share resources among organizations and disseminate lessons learned	Provided technical and financial assistance in the conduct of the 2nd National Micronutrient Symposium. (July 1995)	

NABLING MECHANISMS

Manpower development focuses on training implementors on program management and on skills specific to each impact program, e.g. detection, treatment and prevention of micronutrient malnutritiorr, managing small scale IGPs, etc..

Stronger ***advocacy*** for legislation, sectoral policies and program improvements; including the filing of resolutions on food fortification **and** conduct of studies on the nutritional implications of sectoral policies and plans.

Resource generation targets the national and local governments (LGUs), business sector, nongovernmental organizations (NGOs) and the international community to provide resources for PPAN implementation.

Research provides the basis for decisions on policies program design, and other related aspects of PPAN implementation.

Overall Planning, Management, Coordination and Surveillance to identify specific activities, targets, budgetary requirements and other operational details for projects to be implemrnted in an integrated manner. It also involves close monitoring of plan implementation and of the nutrition situation

BUDGETARY REQUIREMENTS

The PPAN needs an estimated budget of about ***P16.3 billion*** from **1993** to 1998. At least ***P2.6 billion*** will come from NGAs through the General Appropriations. The balance will be generated primarily from LGUs, NGOs, the business sector, and the international community.

ONWARD TO PHILIPPINES 2000

The PPAN is a component of the Medium-Term Philippine Development Plan.

It should be translated into doable and effective programs, projects and activities to achieve the vision of nutritional adequacy for all, and in the process, achieve NIChood in the nutrition sense - Philippines 2000: A Nutritionally Improved Country.

Be a part of the PPAN movement. Call the National Nutrition Council or your local chief executive.

National Nutrition Council
Villamor Interchange, South Superhighway
Makati, Metro Manila
Tel. No.: 844-797 1; 8 18-7398; 8 16-42 11
844-7696; 816-4197; 816-4184
Fax No. 8 16-4280

PPAN

PHILIPPINE PLAN of ACTION for NUTRITION

1 9 9 3 - 1 9 9 8

APPENDIX 4

PHILIPPINES 2000

Tulong-tulong sa Pagsulong

ISION . . .

e Philippine Plan of Action for Nutrition "AN) is the master plan to ensure good irition for all Filipinos, It is the nutrition nmunity's contribution to strengthen the untry's human resource.

HERE WE WANT TO GO . . .

)ALS AND TARGETS. . .

.educe PEM or protein-energy malnutrition (thin and short children) from 1.9% to 8.4% or from 1.4 M to 1 .O M for reschoolers and from 0.8 M to 0.6 M for chool children

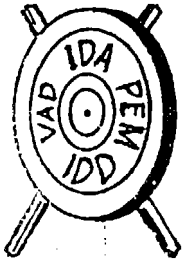
.educe iron deficiency ariemia (IDA) mong infants, pregnant and lactating 'omen, preschoolers and school children by 0% or from 24.3 M to 21.9 M

liminate clinical vitamin A deficiency VAD)

liminate iodine deficiency disorders (IDD)

ıcrease the daily average per capita energy ıtake from 1,872 Kcal to 1,997 Kcal

TO TAKE US WHERE WE WANT TO GO . . .



STRATEGIES . . .

- Promotion of household food security
- Prevention,control and elimination of micro-nutrient malnutrition

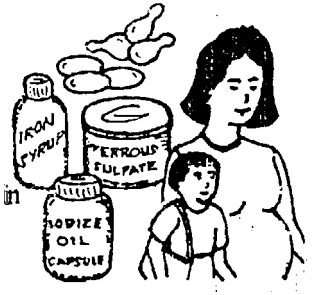
PROGRAMS THAT SPELL THE DIFFERENCE. . .

1. Home and Community Food Production

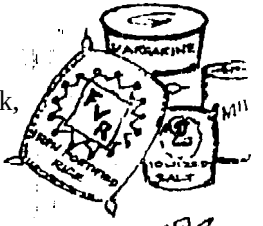
- Establishment of kitchen gardens using the bio-intensive gardening approach and other regenerative agricultural teclmologies
- Raising of small animals
- Provision of water supply system

2. Micronutricnt Supplementation and Food Fortification

- Distribution of iron, iodine, and vitamin A supplements to infants, young children, pregnant and lactating women in preventive and curative doses

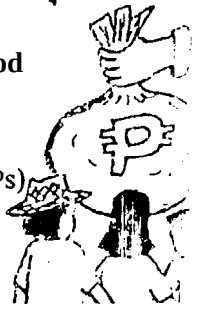


- Fortification of selected food items (e.g. rice, **margarine,** milk, flour) with vitamin **A** and iron, and **salt** with iodine, with the business sector taking the lead



3. Credit Assistance for Livelihood

- Provision of credit assistance to households in Key Nutrition Areas for income-generating projects (IGPs)



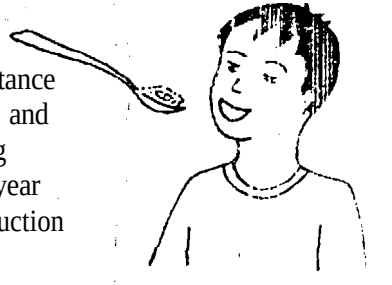
4. Nutrition Education

- Integration of nutrition concepts in the elementary and secondary school curriculum

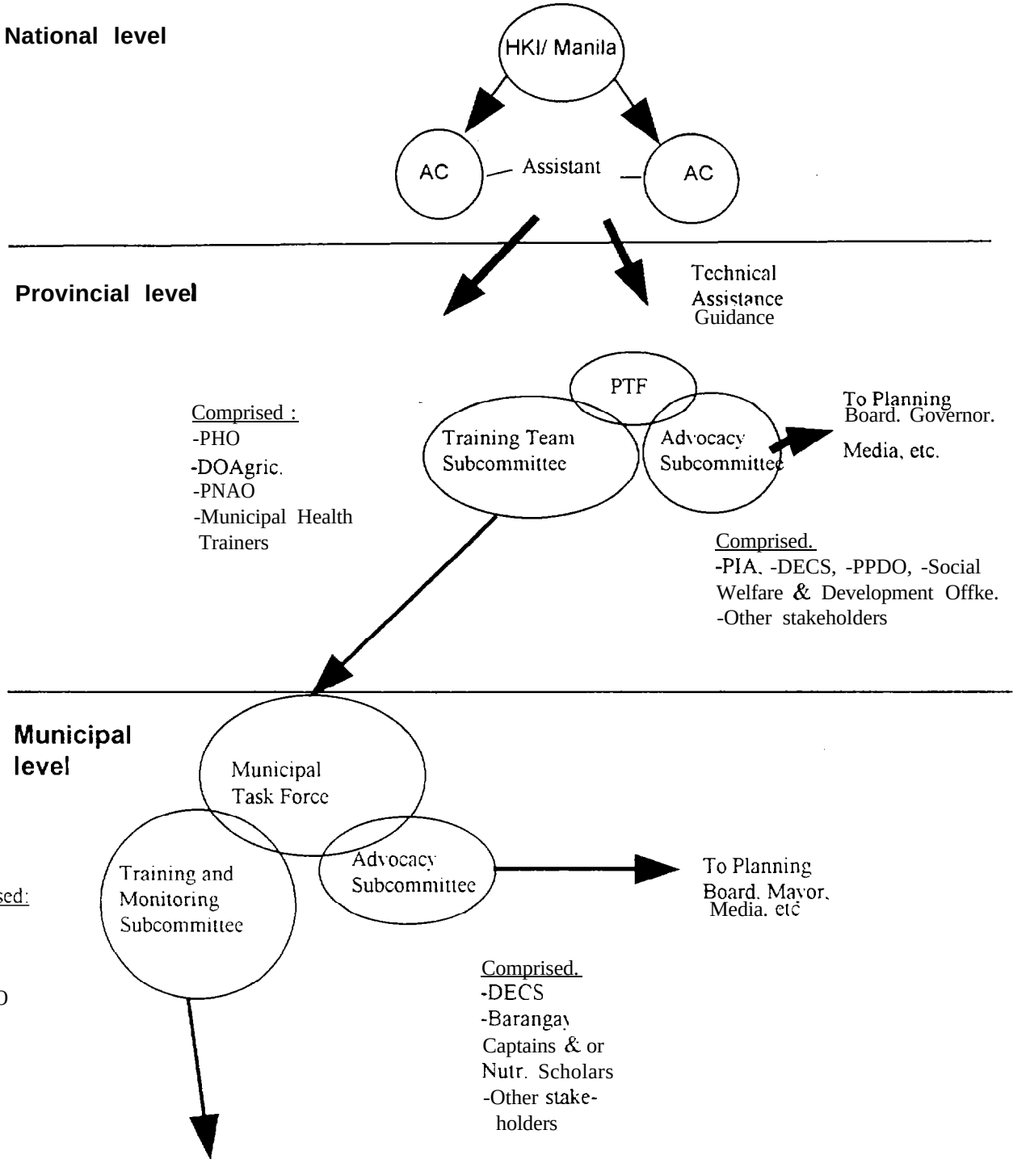
- Provision of quality individual and group counseling on good nutrition
- Promotion of the adoption of good nutrition practices through multi-media and community-based information campaign

5. Food Assistance

- Regular supplementary feeding schemes for the malnourished
- Targeted food assistance scheme for the poor and malnourished during lean months of the year
- Weaning food production and distribution



APPENDIX 5
PROPOSED DESIGS FLOW MODEL SHOWING FLOW OF ACTIVITES



Barangay Interventions
RHMs ---> Mothers' classes
BHWs ----> Mothers' classes and counseling
VAC and Iodine capsule coverage. iodized salt. cooking demonstrations. weighing sessions. EPI. ASAP and National Immunization Day, etc.

Note:
AC = Area Coordinator
PTF=Provincial Tad Force

APPENDIX 6
SUGGESTED PROCESS INDICATORS

Monitoring the Policy Process

Create a **form or** conduct a monthly informal 'survey' with the PTF and when municipal level committees are established to keep track of the following indicators (not all inclusive). Area Coordinators can keep a record of progress in their monthly reports and notebooks. Advertise your biggest successes to media, HKI staff and other organizations as well as with the LGUs.

I. Process Indicators : For Provincial Task Forces*

Indicators of a functioning task force:

1. Regular meetings held (after trainings are complete, meetings are held for other issues including monitoring of the RHMs).
2. Meeting essentials are in place (such as an agenda, note taker, and follow-up plans documented).
3. One point person functioning to facilitate communications inside and outside TF (this can be different from the leader and should be someone who can be contacted easily).
4. Establishment of a regular spot-check monitoring plan for RHM's mother's classes. (Monitoring of the BHWs' monitoring should be done by RHMs and occasionally **by** the PHNs. The PTF members could spot-check and trouble shoot with less frequency).
5. Number of meetings and/or workshops held with Municipal level LGU staff (specify with whom and outcomes).
6. Number of LGU/Municipal level task forces established (and/or nutrition committees reactivated) because of efforts of the PTF.
7. Number of external funding sources identified and contacted.
8. Number of proposals made by the Task Force (describe nature).
9. Specific secondary source data selected from *Health and Nutrition Situation Repon* for ongoing monitoring which are actually monitored routinely (time frame can be monthly, quarterly, annually, etc. depending on type of data and availability from sources.) These indicators should be kept to a minimum and collated from secondary sources whenever possible. For example, number of weighing posts may be determined semi-annually.

Indicators for Information Dissemination:

Note: These are only communications that would not have taken place if a Task Force didn't exist (not communications which are part of the routine of Departments)

1. Number of presentations, speeches. Briefly document content of presentations to Governors, Mayors, LGU Boards, your own Agency, NGOs, other organizations and meetings of other groups (outside the PTF).
2. Number of articles, stories or information spots generated by your task force appearing in newspapers, radio and TV.

3. Number and kinds of informational flyers, newsletters, promotional letters to LGUs distributed and/or mailed out, including the *Health and Nutrition Situation Report.*
4. Number of follow-up communications made with LGU on nutrition issues related to TF activities.
5. Number and kinds of other media opportunities used (e.g., internal and external banners, posters, billboards; e.g., the exposition in the foyer outside the Governor's office in Legaspi).

Indicators for LGUs:

Note: Examples of forms were left with HKI which can be adapted to assess the qualitative information which stems from activities underlying indicators #l and 2 below.

1. Number of LGU staff who became more aware about nutrition issues from reviewing any of the information produced by the Task Force.
2. Number of LGU staff who changed their perceptions (and how they changed) about the nutrition issues in the province/municipality.
3. Number of new contacts or relationships with agencies, organizations or individuals related to addressing the nutrition and health issues as a result of the TF activities.
4. Other ways LGU staff and organizations may have used the information (e.g. sent it to superiors, key people who need the information for their work).

Indicators for municipallbarangay health and nutrition program processes:

(Note: These should be expanded for each topic and a quick check sheet developed for use in the municipalities where HKI will focus on that specific intervention.)

Growth Monitoring:

1. Number of *barangay* weighing posts.
2. Are there sufficient and functional weighing scales in a municipality (at the RHU), in *barangays* (at the BHS) and in *puroks?*

Vitamin A Interventions:

1. Did the VAC run out during the last ASAP or Knock out Polio Day?
2. Are vitamin A capsules available through health services (outside the distributions during ASAP and Knock Out Polio day?
3. Can vitamin A be purchased in the local market?

Iodized Salt Interventions:

1. Is iodized salt available in the local market? (Number of food retailers with iodized salt compared to approximate number of total food retailers)
2. What is the market price? Has it gone up or down over the past month?
3. Is iodized salt use in local restaurants? Is it adequately iodized (> 30ppm?)
4. Number of persons who have become iodized salt distributors as a result of encouragement from the PTF or from information promoted through the PTF
5. Percent of households possessing and using iodized salt

Iron/Anemia Interventions:

1. Are iron tablets available for pregnant mothers at the clinic, hospital, RHUs?

2. Are iron tablets being prescribed by doctors, nurses and midwives?
3. What percent of the midwives report encouraging expectant mothers to take iron for the last four months of pregnancy?
4. Are mothers given enough tablets for complete course (at least two months' worth)?

Moniton'ng:

1. Number of PHN supervisory visits to the (HKI) trained midwives/per month.
2. Number of supervisory visits to the BHWs/month.
3. Number of mother's classes conducted by trained BHWs per month.
4. Number of mothers who request advice from the BHW based on the counseling cards (e.g. is the BHW creating a demand for information?).
5. Use of pre- and post tests by RHMs in mother's classes.

II. Indicators of Impact:

For strengthening the capabilities of the PTFs.

1. Reported increase in skills for: facilitation, training, communication, etc. by the TF members.
2. Reported skills transfer back to the department or agency of the TF member.
3. Skills transfer within the TF (one or more members share a unique and needed skill for other members to effectively promote goals of the TF.

For program sustainability and improving program effectiveness:

1. Number of LGU staff and other persons/organizations who acted upon the information produced and disseminated by the Task Force. Specify action:

- Fulfilled in whole or part a request for funding including: for staff, materials, training, travel (document amount of funds and types of materials, staff, other assistance)
- Pledged money for nutrition issues (specify funding level and purpose for funds)
- Establishment of a subcommittee on a specific nutrition issue because of TF efforts
- Number and kind of actions organizations have taken to improve or focus on service delivery because of TF activities and/or information

2. Development and/or enactment of legislation favorable to nutrition goals (e.g. salt legislation which has enforcement guidelines)
3. Policy change(s) made (nutrition-related)
4. Processes changed that affect implementation of nutrition programs (such as reducing time spent on nutrition month and increasing time spent on teaching mothers appropriate weaning foods)
5. Better coordination and cooperation between and among agencies as evidenced **by:**
   - coordinated travel schedules for monitoring and service delivery;
   - cooperation between agencies to get the nutrition-related task done

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* Attention of HKI's Area Coordinators should not only be on monitoring the processes, but monitoring the quality of the processes as well

Health and Nutrition SITUATION REPORT - 1995

Albay

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TECHNICAL WORKJNG GROUP
CHILD GROWTH PROJECT
Province of Albay

VERONICA M. MADULID, MD, MPH
Pfovinciul Health Officer
Chairman

Members

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Project Evaluation Officer II
Provincial Planning und Development Office

CAROLINE A. LEONES
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Provincial Planning and Development Office

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Nutritionis ***t/Die titian***
Provincial Health Office

MILWIDA RACHO
Nurse
Provincial Health Office

MARI ANN **ESQUIVEL**
Health Educator and Piomotions Officer
Provincial Health Office

MELITA ALFORTE
Statistician Aide
Pfovinciul Social Welfare and Development Office

Message

Through this Provincial Health and Nutrition Situation Report, I am happy to greet and congratulate all the people who are involved in the implementationof the CPC IV Breastfeeding, Weaning, Growth Monitoring Project or the 'CHILD GROWTH PROJECT'. . . . ..asupplementarycomponentofthePPACTmaternaland nutrition program framework, especially the UNICEF, AusAID and Helen Keller International and theTechnical Working Group of the Project for a job well done. No **doubt,** your continuing commitment and dedication to attain the project's lofty goals and visions will be the ultimate key to its success.

This CPC IV 'Breastfeeding, Weaning and Growth Monitoring Project (Child Growth Project), will expand and improve our delivery of health care services to children and reduce child malnutrition, as well as address the nagging problems of poor maternal health, decline of breastfeeding practices, close birthspacing, improperweaning food practices, inadequate care of the sick child and minimal attention given to the psycho-social development of the child.

It is important, therefore, for this undertaking to succeed not only here in Albay, but elsewhere in the country where malnutrition and infant mortality rates are still high. We owe it to our children for them to grow healthy, productive and worthy citizens of our community. For only with a healthy citizenry can we develop and progress as a people and as a nation, Hence, let us support this 'CHILD GROWTH PROJECT'.

Mabuhay!

A

AL FRANCIS BICHARA
Governor

Major Outputs (Training Workshops Conducted)

Course Title	Purpose & Expected Output	Course Duration	No. of Pax attended	Target Trainees
Workshop on the Assessment of the Prov'l. Health and Nutrition Situation (Child Growth initiated)	•To review and enhance the Provincial Health and Nutrition Situation to establish baseline data in the eight (8) provinces for breastfeeding, weaning and growth monitoring and promotion campaign. ***Outputs:*** •Protocol for FGDs, in depth interview in each province •Preliminary situational analysis in each province •Plan of action in the conduct of data collection •Draft Health & Nutrition Situation Report for the provinces of Albay, Masbate, E. Samar & Leyte	4 days •Sept 27 - 30,1994	24	•Members of the Provincial Task force •Prov'l Maternal and Child Health Coordinator •Provincial Nutrition Coordinator •Provincial Health Educator •Provincial Agriculture Office •Provincial Social Welfare & Dev't Office •Provincial Planning & Dev't office
Follow-up Workshop on the Provincial Health & Nutrition Situation Report Analysis (Child Growth initiated)	•To finalize their Provincial Health and Nutrition Situation Analysis Report ***Outputs:*** Final Report of Provincial Health & Nutrition Situation for Albay, Masbate, E. Samar & Leyte	4 days •Dec. 5 - 8, 1994	24	#Members of the Provincial Task Force
Workshop on the Dev't. of Prov'l. Communication Plan	•To develop provincial communications plan for Masbate, Albay, Leyte & Eastern Samar ***Outputs:*** Communications Plan for the 4 provinces	4 days •Jan 30 - Feb 2, 1994	24	•Members of the Provincial Task Force

Course Title	Purpose & Expected Output	Course Duration	No. of Pax attended	Target Trainees
. Workshop on the Dev't. of the Basic Learning Package	›To design new learning sessions for new messages based on experiential learning approach ***Outputs:*** ›Learning sessions for pre-natal, breastfeeding and growth monitoring	5 days •April 24 - 28, 1995	19	Health Educator from each province DOH - MCH DOH - PIHES DOH - HOMS DOH - NS National Nutrition Council
. Start-up /Orientation Workshop	›To formally introduce HKJ in 4 CSX provinces and determine the technical assistance needs of the province to further strengthen the Nutritin Program of the province	2 days ›July 6-7, 1995	23	#Members of the Provincial Task Force
I. Training needs Assessment Workshop	›To identify the training needs of the provincial training team and to train them to conduct Training Analysis and to develop a training design ***Outputs:*** ›List of training needs of the Prov'l Training Team ›Training of Trainees Training Design ›Training Needs Assessment Tool for Midwives/BHWs	5 days ›Aug 14 - 18, 1995 ›Sept 11-15, 1995	14 14	›Members of the Provincial Training Team
. Training of Trainers on the Use of the Basic Learning Package	›To strengthen the capabilities of the Provincial Training Teams to train midwives and BHWs in the conduct of mothers classes and in counselling of mothers using the Breastfeeding, Weaning and Growth Monitoring Basic Learning Package	5 days ›Nov 20-24, 1995 ›Nov 27 - Dec 1, 1995 ›Apr 22 -26, 1996	14 14 39	›Members of the Provincial Training Team ›DOH/NNC - Region

Course Title	Purpose & Expected Output	Course Duration	No. of Pax attended	Target Trainees
CSX - Nutrition Intervention Planning Workshop	•To analyze the health and nutrition situation of the province to come up with a feasible plan of action for Child Survival Project *Outputs:* •List of nutritional problems •List of Interventions •Nutrition Intervention Plan •Updated Health & Nutrition Situation of Albay, Masbate, Leyte, E. Samar & N. Samar 'Draft - Health and Nutrition Situation of the Province of Biliran, Southern Iqte & Samar	4 days •Feb 12 - 15, 1996	30	•Members of the Provincial Task Force and the Provincial Health Officers •Regional Nutrition Council •Regional Health Office
Planning Workshop	•To formulate/develop Provincial Nutrition Action Plan *Outputs:* 'Identified training needs of the Province •Provincial Nutrition Plan in each province	2 days/ province •Mar 5 -6 •Mar 12-13 •Mar 14-15 •Mar 25-26 •Mar 28-29 •Apr lo-11 •Apr 15-16 •Apr 17-18	 16 10 18 20 16 20 12 15	Provincial Task Force & Prov'l Nutrition Comm. 'Southern Leyte •Leyte •Biliran •Samar 'Eastern Samar 'Nor-then Samar 'Ma&ate •Albay
). Workshop on Nutrition Program Advocacy for Local Gov't. (for the entire Nutrition Service Staff of the Department of Health)	•To identify available tools which can be used and advocated to the LGUs for implementing nutrition program and develop advocacy strategy on how to promote nutrition package at the LGUs *Outputs:* •List of Key Nutrition Intervention approach to LGUs 'Advocacy plan to promote -Basic Nutrition Intervention" at the LGUs	2 days 'June 20 - 21, 1996	35	'Dept. of Health - Nutrition Service Department

Course Title	Purpose & Expected Output	Course Duration	No. of Pax attended	Target Trainees
Training of Rural Health Midwives In Conducting Mothers Classes on Use of the Basic Learning Package	To familiarize midwives with the messages in the Basic Learning Package To relate experiential learning cycle with the sessions in the Basic Learing Package To demonstrate some facilitating skills that they can use in conducting mothers classes and develop plan of action for the conduct of mothers classes	5 days day 6-10 May 20-24 May 20-24 May 27- 31 My 22 - 26 luly 29 - Aug 2	 59 (2 grps) 21 33 29 32 24	Rural Heath Midwives Eastern Samar Ubay vlasbate Leyte iouthem Leyte 3iliran
Workshop on Nutrition Program Advocacy for Local Gov't. Units (for Provincial Task Force and Provincial Nutrition Committee	To upgrade the competencies of Local Government Units at the Provincial Level in the conduct of Nutrition Program Advocacy to be able to generate commitments from the Local Chief Executive outputs: List of Key Nutrition Intervention Approaches to LGUs List of Advocacy Strategies to increase awareness level of LCES of the nutrition problems and services Advocacy Plan	3 days My 15 - 17, 1996 July 17 - 19, 1996	37 43	Provincial Task Force and Provincial Nutrition Committee of Biliran and Southern Leyte Provincial Task Force and Provincial Nutrition Committee of Samar and Northern Samar
Training of Community Volunteer Health Workers on Counselling Skills Using the Counselling Cards	To equipped the Community Volunteer Health Workers using the Counselling Cards and to familiarize themselves with the messages in the Counsellinng Cards	5 days Aug 5 - 9, 1996 My 22 - 26, 1996	 32 54	Community Volunteer Health Workers of: Masbate Eastern Samar

APPENDIX 9
TRAINING DESIGNS DEVELOPED

1. Workshop on the Assessment of the Provincial Health and Nutrition Situation

2. Follow-up Workshop on the Provincial Health and Nutrition Situation Analysis and KAP Assessment among Mothers on Prenatal Care, Breastfeeding, Weaning and Growth Monitoring

3. Workshop on the Development of Provincial Communications Plan for the CPC IV Breastfeeding, Weaning, Growth Monitoring Project

4. Workshop on the Development of the Child Growth Basic Learning Package

5. Start-up meeting on the Child Survival X Project (LGU-RNC-RHO-PIA-HIU)

6. Workshop on the Training Needs Analysis and Training Design Development

7. Training of Trainers on the Use of the Breastfeeding, Weaning, Growth Monitoring Basic Learning Package

8. CSX Nutrition Intervention Planning Workshop

9. Workshop on Nutrition Program Advocacy for Local Government Units

10. Training Curriculum for Midwives on the use of the Child Growth Basic Learning Package

11. Training Curriculum for *Barangay* Health Workers on the use of the Child Growth Basic Learning Package

Appendix 10

HKI Personnel and Staff

Name	Title	Level of Support	Duties
Rolf Klemm	l'roject Director	33%	Policy Development
Ellen Villate	Deputy Director	100%	Project Management
Daylyn Sandrino	Project Manager	50%	Day-to-day operations
Chato Tuason	HI S Manager	50%	Health Information System
Cecila Lim	Finance	50%	Monitoring and Financial Supervision
Ma. F. Dolly Rear-lo	Area Coordinator	100%	Monitoring & Technical Supervision
Asela Querol	Area Coordinator	100%	Monitoring & Technical Supervision
Berna Ungson	Research Assistant	83%	Health Information System
Alfie Hilario	Production Officer	44%	Communications
Eva Puertollano	Communications Officer	50%	Communications
Virnaliza Lumbao	Admin. Secretaq	78%	Administration
Mita Severino	Accountant	33%	Financial Support
Julieta hlarino	Bookkeeper	33%	Financial Support
Abundio Oribiada	Logistics Officer	33%	Administration Support
Protacio lsip	Driver	100%	support